	•	For State Registrar	State of	Maryla	•	artment o				giene Reg. No.	006	14001
		Decedent's Name (First, Middle, Landson)	ist)				-		2. Date of De			3. Time of Death
Physicia	n	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Lucille	e R.	Grogg				Month May	1, Day	2006	10:30 A ^M
/Medica		4a. Facility Name (If not institution, gr			02088	4b. City, Toy	vn, or Location		1147		County of Deat	
LAMITING	-1	Shady Grove Ad	ventist 1	Hoent	i a 1	Rock	ville			Mo	ntgomei	·v
Funeral		5. Social Security Number 6.	Sex 7		s. last birthday	If Under 1 Y	ear If Und		8. Date of Bir (Month, Da		9. Birt	nplace (State or Foreign
Director		219-03-4993	1 ☐ M 2 🕅 F	88	Yrs.	Months D	ays Hou	rs Min.	June 27	7 , 19:		untry) ginia
P	Ì	Usuaf Residence of Decedent		10	O: T							
arylar	_	10a. State 10b. County		100.	City, Town or L	ocation.						10d. fnside City Limits 1 X Yes 2 ☐ No
80-1-08	cto	Maryland Montgom	ery		Rock	ville_						
vith th	5	10e. Street and Number				10f. Zip Co					en of What Co	,
036 burs after death with the Marylan rel', or iteme 23e or 28e-f ehow Exeminer must be notified at	rai	9701 Veirs Driv			110		20850	0::0/0	7 17 11		ed Stat	
er de	nu	11. Marital Status	12. Was Deced	es?	0.5.	Was Decedent If Yes, specify	Cuban, Mexi	ican, Puerto P	city Yes or No Rican, etc.))-	 Race - Ame Black, White 	
36 rs aft	Ş	1 ☐ Never Mamied 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2 🔀	No Spec	cify:			Specify: Wh	ite
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-1 show he Madical Examiner must be notified at	Completed by Funeral Director	15. Decedent's E			16a. Dece	edent's Usual C	ecupation		_	16b, Kin	d of Business/	Industry
215 7 nic 72	ple	(Specify only highest gi	ade completed)	40× 5 + \	(Give	e kind of work of DO NOT use r	lone during n etired)	nost of workin	g			•
d with	E	12	College (1-	40r 5+)	Cle	rk				Pos	tal Ser	vice
other tile	BeC	17. Father's Name (First, Middle, Las	t)		·		18. Mc	other's Name	(First, Middle	. Maiden S	Surname)	
ria by rice of tice of	70 E	Arthur G. Rupar	đ					Lena F	R. Urps	3		
Maryland 21215-0036 d 2 should be tiled within 72 hours att the and Mental Hygiene. 27 is marked other then "natural", or treumatic event, the Mudical Exami		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ling Address (S	treet and Nui	mber or Rural	Route Numb	er, City or	Town, State, 2	Zip Code)
mand 2 auth 27 is		Robyn H. Bloodgo	od/Great	niece	4017	Tranqu	ility	Court,	Monro	via,	Maryla	nd 21770
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other treumatic event, the Mance.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 I	Bomoust from S	1	. Place of Disp cemetery, cre	osition (Name of	of r place)	May Da	ate 4,	20c. Loc	ation - City or	Town, State
Pag Pag nent ant: b		4 □Donation 5 □ Other (Spec		Pa	rklawn M	emorial I	Park	2006		Rock	ville,	Maryland
Balt permit. Depart Importa		21. Signature of Funeral Service Lice	nsee /		R/	22. Name and A	ddress of Fa	acility	al Homa	/Poola:	rillo Tr	0
0 80 5 5 8		Mayeletu	mest	MO 1	$305 \frac{1}{30}$	00 West M	ontgome	ry Avenu	ie, Rock	ville,	Marylar	nd 20850-2805
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that car one cause on a	used the de ch line.	ath. Do not er	nter the mode o	f dying, such	as cardiac or	respiratory a	rrest,		Approximate Interval Between
Physician		fmmediate Cause (Final disease or condition	P	eric	ar die	1 184	fusi	m				Onset and Death
/Medical		resulting in death)	Due to (o	r as a cons	equence of):						-	0,1,1,0,0,0
Examiner weculed and all-transit		Sequentially list conditions.	b									
M / B #	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a cons	equence of):							
8760, Cate be executed by sicien and the burial-transit	Cam	that initiated events resulting in death) Last	C									
00 a mix	<u>~</u>	,	0) 01 6000	as a cons	equence of):							
% star of the star	dical	•	d									
ds, P.O. Box 6876 irres that the death certiticate bisigned by the attending physic d be detached for use as the b	by Physician/Me	fF FEMALE:	23c. If yes, outc	ome of ores	maney						0.4 D-16.4	
Box Bath cert attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live bir 4☐Pregna	th 2 🗆 F	etal death 3	☐Ectopic pregr ☐ Other (special				2	3d. Date of dea Month	overy Day Year
O et et bed	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknov		rueani 5	□ Other (specia	9/					
Cille 5/1/206 Records, P.O. Box 6 The law requires that the death certification is the been signed by the attending oage 2 should be detached for use as	된	Part II. Other significant conditions	contributing to dea	th but not r	esulting in the	underlying caus	e given in Pa	art I.	23e. Did t	obacco us	se contribute to	the cause of death?
Vital Records, vital Records, certificate hes been signer rector, page 2 should be		Atrial FL	tter						10	Yes 2]No 3 □ Pi	obably 4 Unknown
tal Record in: The law requir	Completed								24a. Was	an	24h Were a	itopsy findings available
ACLI II Rec The lav atte hes	g I								auto		prior to death?	completion of cause of
		OF Manager referred to medical							1 Tes	2 No	1 🗆 Yes	2□ No
of Vita Of Vita Physician: this certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	patient 2	☐ ER/Outpatie	ent 3 DOA	Othor		(Check only		CO11 /0	-4.1
on of	. To	27. Manger of Death	28a. Date of	Injury	28b. Time	of 28c.	Injury at		8d. Describe		Other (Spe	ciry)
on ading it is a street of tunering it	į	1 Natural 5 Pending 2 Accident investigate		, Day Year)	Injury	м	Work? 1 ☐ Yes 2	! □ No				
Division Division of or Attending after death. Director: Attention by the funer	Certification;	3 Suicide 6 Could not	28e. Place	of Injury - Al	home, farm, s	treet, factory, or	ffice	2	8f. Location (Street and	Number or R	ural Route Number,
G part din	ert	4 Homicide	bullain	g, etc. (Spe	icity)				City or To	wn, State)		
		29a Certifying F	hysician: To the b	est of my k	nowfedge, dea	th occurred at t	he time, date	and place, a	nd due to the	cause(s)	and manner as	stated.
the Hc nin 24 I the Fu	Medical	(Check only one)	miner: On the bas	sis of exami er stated.	ination and/or i	nvestigation, in	my opinion,	death occurre	d at the time,	date and	place, and due	to the cause(s)
To the within comp	Σ	29b. Signature and title of certifier	1,				icense numb			29d. Date	signed (Mont	h, Day, Year)
		John Mary	May	M	D,	00	0062	653		Ma	y, 1,	2006
2		30 Name and address of person who	completed cause	of death (I	tem 23a) (Type	, Print)					1	
2		Kobert Ryan +	lolmes	990	1 Medio	cal Cen	ter Dr	ive, R	ockvil	1e, M	Marylan	d 20850
Stat Registra		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sig	mature	6						

ORIGINAL

			For State Registrar		State o	f Marylar		rtment tificate				lental H	ygien Reg. K	$\Omega \cap \Omega$	6	14002
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В	Physici		George	Ha 11								Apri			Year 206	0840 ^M
	/Medic Examir	-	4a. Fecility Name (If no		give street and nu	mber)		4b. City, To	wn, or l	Location	of Death	Lipia		c. County of		0040
		1.74	Hopkins El	lder P	lus Ass.	Living		Sparr	OWS	Poi	nt.		В	altim	ore	
	Funeral		5. Social Security Num		S. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under Hours		8. Date of E (Month, I Mar.	Birth	()	9. Birthp	place (State or Foreign
*	Director		213-22-084	6	1 X M 2□F	87	Yrs.	MONTHS	Days	Hours	IVIII I.	Mar.	19, "	1919	Mar	ÿland
	, od		Usual Residence of De	ob. County		100 Ci	ty, Town or Loc									
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	vith ti	吉	10e. Street and Number	er				10f. Zip C					10g. C	Citizen of W	hat Cour	ntry?
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21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f ehow ta Medical Exer. dier med be ricilited at	by Funeral Director	11. Marital Status 1 X Never Married 3 ☐ Widowed 4 [Armed Fo	2XNo ve	lf	Vas Deceder Yes, specify □Yes 2X				ecify Yes or the Rican, etc.) ${\tt Ck}$	No-		, White,	
2-0	72 hc	Completed		Decedent's	Education grade completed)		16a. Deced	ent's Usual (Occupat	tion	t of work	ina	16b.	Kind of Bus	iness/in	dustry
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pu	2 should be filed within 72 hours and Mental Hygiene. ie marked other than "naturel", aumatic event, It a Medical Exa	Be	17. Father's Name (Fir	st, Middle, La	ast)					18. Mothe	er's Nam	e (First, Midd	le, Maide	n Sumame)	
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Maryland	d 2 should th and Men 7 is marks traumatic		19a. Informant's Name			_						al Route Num				Code)
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0	2 to 1		20a. Method of Dispos	iition Cremation 3	B □Removal from		Place of Dispos cemetery, crem	atory or othe	or er place)		Date	20c.	Location - 0	City or To	own, State
Ē	men tant: jury		4 Donation 5	Other (Spe	ecity)		tro Cre					1, 06	Ba1	timore	e, M	aryland
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funer	ral Service Li	chla	ngn		Name and Cremat 299 Fr	ion ede	of Facility Soci rick	lety Road	of Mai 1 Cator	ryla: nsvi	nd, II	nc. MD 2	1228
			23a. Part V Enter the c shock, or heart fa	disease, or o	omplications that only one cause on	caused the deat	th. Do not ente	r the mode	of dying	, such as	cardiac	or respiratory	arrest,			Approximate Interval Between
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D.	es tha igned be det	by P	Part II. Other significa	nt condition	s contributing to d	eath but not res	ulting in the un	derlying cau	se giver	n in Part I		23e. Did	tobacco	use contri	oute to th	ne cause of death?
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1 of			27. Manner of Death			of Injury th, Day Year)	28b. Time of		Injury			28d. Describ				iving
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Vis	if or Attend atter death Director: / in by the t	2	3 ☐ Suicide 6	6 Could no determin	ad 288. Place	e of Injury - At he	ome, farm, stre	et, factory, c	ffice			28f. Location City or T			r or Rura	I Route Number,
	s after or sale of all Div	Cert	· C Homeles		Dalid	ing, etc. (Specii	y/					Ony or 1	OWN, Sta	10)		
	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Atte completaly lilled in by the tune	Medical	29a. Certifier 1.2 (CHBCK OTHY 2.1 one)	Certifying Medical Ex	Physician: To the caminer: On the band man	e best of my kno asis of examina ner stated.	owledge, death ation and/or invi	occurred at estigation, in	the time	e, date an nion, dea	d place, th occurr	and due to the	e cause(e, date a	s) and man nd place, ar	ner as si nd due to	ated. the cause(s)
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4	2 \ \		30. Name and address					Print)	Λ		n				_	1224
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DH	Registr	a ""	AM	Y 0 4	2006	Que A	in figure									

State of Maryland / Department of Health and Mental Hygiene 14003 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Mary R. Hanvey 8:10 PM May 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton 8020 Temple HIII Road Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 251 20 5083 79 Director Dec 16, 1926 South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "natural", or items 23s or 28s-f show treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 8020 Temple Hill Road 20735 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 Tho þ Specify. 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virgil Johnson Carrie Poteat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Kathy Dodson (Daughter) 4710 Maui Street, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) May 10, 02006 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, MD 22. Name and Address of Facilin Lee Funeral Home, Inc 6633 01d 21. Signature of Juneral Pervise Licensee Alexandria Ferry Road,Clinton, MD 20735 art1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a month /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examiner certificate be executed ng physicien and as the burial-transit P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2/11 No certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 1 ANaturaf 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time. Sate and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46246 WALDORF May 3, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 M. ASHA . Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 Month **Physician** May 1, 6:10 A M Gary M. Hypes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genisis Eldercare LaPlata Charles If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) June 11,1938 9. Birthplace (State or Foreign **Funeral** 1**☑**M 2□F Days Hours West Virginia 233 58 4674 67 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√3No Director Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5329 West Boniwood 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give TX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐Ne 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales (Ret) YOur Living Room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cora Bloheld Jennings Hypes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hollis Hypes (Wife) 5329 West Boniwood Turn, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) May 4, 2006 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott VXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Suitland, MD 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Fun val Service Licensee Alexandria Ferry Road, Clinton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (CIRRHOSIS END STACK. **Physician** /Medical Due to (or as a consequence of) Examiner HRUNI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 0 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

The law requires that the death certificate be executed o <u>م</u> Division of Vital Records, To the Hospital o within 24 hours eff To the Funaral Di

the Maryland

within 72 hours after

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Maryland

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Box

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ie marked other traumatic event.

If item 27

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been signed by the should be detached

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efter death.

Director: Aff

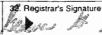
filled in by

1 and 2 should be Health and Mental

State Registrar

31. Date filed (Month, Day, Year) MAY 0 4 2006

29b. Signature and title of certifier



30. Name and address of Ger of who completed cause of death (Item 1991) 66, Print)



29c. License number

29d. Date signed (Monta, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death cedent's Name (First Middle, Last) **Physician** tenderson Inorri -06 /Medical 4a. Fecility Name (If not institution, give street and number)
1364 Pentwood 4b. City, Town, or Location of Death 4c. County of Death Examiner Koad Atimore ar If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Min 1**X**M 2□ F 217-68-125 Usual Residence of Decedent Director 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits the Medical Examiner roust be notified at 1 Yes 2 □ No Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 366. LSA Was Decedent Ever in U.S. Armed Forces? → Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ify only highest grade completed) 16b. Kind of Business/Industry Elementar (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental Healt if Item 27 Is marked of ores ပ္ Mother 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code, 0+48, Date permit. Pages 1 and 2:
Department of Health ar
Important: if Item 27 te
eny injury or other trau -0c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee luc 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the dean. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours atter death.
within 24 hours atter death.
To the Funeral Director: After this certificete hes been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 2 ☐ No o 9 Unknown Part II. Other significant conditions opntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, tase 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy rmed? 200 No 1 Yes 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier Name and BELVEDENE 31. Date filed (Month, Day, State MAY 0 4 2006 Registrar

HENDEPSON

RAYNAED

			1 - For State Registrar	State of Ma	aryland / De		nt of He		Re	g. No.	06	14006
	Physici	20	Decedent's Name (First, Middle, La.						2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al .		inski					April	28,	2006 inty of Death	10:55P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			onium	Location of Death	1		altim	
			Stella Maris 5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthda		r 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Foreign intry)
	Funeral Director		165-16-1138	X M 2□ F	86 Yrs.	Months		Hours Min.	Dec. 20.	1919	Penn	sylvania
			Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	nylan show	_	10a. State 10b. County		10c. City, Town or							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-1	cto	Maryland Baltimor	<i>le</i>		Balti						
	or 24	Dire	10e. Street and Number			10f. Zij	p Code	21236	11		of What Cou	intry?
	23e	Funeral Director	4004 Silvage Roc	12. Was Decedent	Ever in II S 1	3 Was Dece	dent of His		necify Ves or No.		Race - Amer	ican Indian
	item item	un.	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	No. 3.			, Mexican, Puert	pecify Yes or No- o Rican, etc.)		Black, White	
936	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WW II	1 🗆 Yes	2 A No	Specify:		Spe	ecity: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neture!, or Iteme 23a or 28a-f ehow event, Ite Medical Exartical must be notified at	Completed	15. Decedent's Ed	ducation	16a. De	cedent's Usu	al Occupa	tion uring most of war	kina	16b. Kind o	f Business/Ir	ndustry
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	(+)			uring most of wor		D a + la 0	ehem s	2+008
2	Hygier Hygier sther th	ပိ	12		S.	teamfi		19 Mother's Nas	ne (First, Middle, M			sieei
and	be fill H	Be	17. Father's Name (First, Middle, Last, Constantine Ho	vrlinski				Anna	Cant	naideir Jui	name)	
્ટ્રેં	d Mei d Mer nark	ဥ	19a. Informant's Name/Relationship (19h M:	ailing Addres	s (Street a		ral Route Number	City or To	wn. State. Zi	in Code)
Maryland	and 2 should be ealth and Mental nr 27 is marked o		Mrs. Deborah Mell	*					altimore,			,
	Heal Heal tem 3		20a. Method of Disposition		20b. Place of Discemetery,						on - City or 1	Town, State
10:55 Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importement of Health and Mental Hygiene. Importement: if item 27 is marked other then "neturel", or iteme 23a or 28a-1 ehow any higher other treumatic event, its Medical Examinal must be notified at 2018.		1 ☐ Burial 2 ☐ Cremation 3 💆 4 ☐ Donation 5 ☐ Other (Specif						1/2006 A	rling	aton,	Virginia
10:	permit. I Depertm Importer eny injur		21. Signature of Funeral Service Licer			22. Name a			chimunek			
ñ	Depermine on yir		Buair all	Ille		9705	Belai	ir Rd.,	Baltimore	, MD	21236	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	ne.		4		or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		MAZU	m 6 1	2/ 4	-				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	1-10/	- </td <td>10/25</td> <td>></td> <td></td> <td></td> <td></td>	10/25	>			
90	Examiner		Sequentially list conditions,	b								
2006	pe #isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):							
00 -	ate be executed hysicien end he buriel-transit	xan	that initiated events resulting in death) Last	c Due to (or as	a consequence of):	-						
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777 68	g phy as the	-								1		
APRII Box 68	death certifica e ettending ph d for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic p	oregnancy			23d	Date of deli	•
	deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		5 Other (s					Month	Day Year
P.0	at the 1 by th stach	Phy	9 Unknown					a in Part I	22a Did to		nontributo to	the cause of death?
	igned bed	2	Part II. Other eignificant conditions	contributing to death b		e undertying	cause give	m in Part I.			lo 3 Pro	-
Orc	requi	eted	Teasof.	L .					-			
HARLINSKI Vital Records,	The law requires ite hes been sign bage 2 should be	Completed		50/416	- ,				24a. Was a autops perfori	n 2 y ned?	prior to death?	topsy findings available completion of cause of
R.L.	icete			50/4 16:	> 3				1 ☐ Yes	2 200	1 🗆 Yes	2 No
Vit	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	αΠΕΡΙΟ. I		Othe		ath (Check only or		Othor (Con	
o ₹	Phys rathis	5	1 ☐ Yes 215 No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpa		28c. Injury Work		fome 5 ☐ Reside			ny)
OH	Attending r deeth. ector: After	ş	1 Statural 5 Pending 2 Accident investigation		y Yea <i>r)</i> Inju	м		r? Yes 2 ☐ No				
ANTHONY Division of	Attendi	ffca	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of In	ury - Al home, farm c. (Specify)	, street, facto	ry, office		28f. Location (S. City or Town		u <i>mber</i> o <i>r R</i> u	ral Route Number,
Ö	rs afte	Certification:	- I HORRIGO	bulluarig, et	o. (openiy)				5, 5 511	,		
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after deeth. To the Funeral Director: After this certificate hes been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	cal		hysician: To the best								
	the hin 24 the F	Medical	one)	and manner st								h, Day, Year)
	Vit Con	2	29b. Signature and the of certifier	bede	RI		9c. License	150			- //	
	211		7/									
	180		30. Name and address of person who				יס עי	חדאים	NITIIM MI	2100	3	
	C+	ate	EDDIE NAKHUDA, 31. Date filed (Month, Day, Year)	-	O DULANEY rar's Signature	VALLE	I KUF	A TIMO	WIUM, MD	2109.		
	Regist		MAY 0 4	2006	and St. 1	Comple	1					

			1 - For State Registrer	State of Maryla			nt of H		nd M		Reg. No.	06		4007	
	Physici /Media		1. Decedent's Name (First, Middle, Las	HAAS		,				2. Date of De Month APRIL	Day 2	92	(ear	3. Time of Death	
	Examir Funeral	er	5. Social Security Number 6. S	SPITAL (ex 7. Age (In y	ENTER	If Unc	er 1 Year	If Under 2	(M)	O RE	th	County of n/a	9. Birthpla	ace (State or Fore	ign
	Director		220-26-9261 Usual Residence of Decedent	□ M 2 💢 76		Month	s Days	Hours	Min.	Dec.	23 1 9		Count W\	y) ·	
	he Marylan 28e-f show	ector	MD n/a 10a. State 10b. County n / a		City, Town or Lo		ip Code				10g. Citiz	of 14/h		d, Inside City Limi	
9003	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Iteme 23a or 28e-f show or other traumatic event, the Medical Examinar must be multised at	d by Funeral Director	524 N. Charles S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dec If Yes, sp	2120 edent of Hi becify Cuba 2 X No	ispanic Orig n, Mexican, Specify:	in? (Spe , Puerto f	cify Yes or No Rican, etc.)	- 1	4. Race - Black, Specify:	SA America White, e	n Indian, tc. hite	
21215-0036	filed within 72 i Hygiene. ther than "nat int, the Medica	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	kind of v DO NOT	vork done d use retired	durina most	of workir	ng		nd of Busi		ind Co.	
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mi	To Be C	17. Father's Name (First, Middle, Last) John Lewis	•				Franc	ces		. <i>Maiden</i> . st na	Sumame) i me ւ	unkn	own by	
Baltimore, Mar	Pages 1 and 2 sh nent of Health and int: If Item 27 is m iry or other traum		19a. Informant's Name/Relationship (7 Elmer Haas/husba 20a. Method of Disposition 1 □ Gurial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specification 1)	nd 20t	524 No. Place of Dispo	sition (N	harle ame of other place	s St.	Apt 0/3/0	t. 401.	Bal	to., cation - Ci	MD ity or Tov	n, State	
Baltin	permit. Pag Department Important: b any injury o		21. Signature of Funeral Service and Michael J. Fl.	2916	22	Name	and Addres	s of Facility	,	ne of D Timor				ID 21093 y, Inc.	
A.	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the drone cause on each line. a. METHICLL Due to (or as a cons	eath. Do not ent	ter the m	ode of dyin	g, such as c	cardiac o	r respiratory a	rrest,	PSU		Approximate Interval Between Onset and Death	۷.
8760,	rate be executed whysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SMALL Due to (or as a cons c. SEVERE Due to (or as a cons RES P	sequence of): MAL sequence of):	NU	TRI	TIO	Ν.	ON.	,		>	2 mon	
.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preduction 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	∃Ectopic ∃ Other (pregnancy specify)		San Property		2	3d. Date (y Day Year	
Δ.	ngi bed	by	Part II. Dther significant conditions of	ontributing to death but not	resulting in the u	nderlying	cause give	en in Part I.		23e. Did t				cause of death?	VΠ
i Records,		Completed								24a. Was auto perfo 1 🗆 Yes		dea	ath?	sy findings availat pletion of cause o	ole f
	ding Physician: 7 h. After this certifica funeral director, p	ion; To Be	25. Was case referred to medical examiner? 1 Yes 22 10 27. Manner of Death 1 Autural 5 Pending	28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time of Injury	f	28c. Injury Work	or: 4 □ Nur: vat k?	sing Hon	(Check only one 5 Resi	dence 6				
Division	or Attentifier deet Director; in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm, str ecify)	M reet, facto		Yes 2□N	-	8f. Location (City or To		Number	or Rural	Route Number,	
		edical (29a. Certifier 1 Certifying Ph	ysicien: To the best of my lands. On the basis of exame and manner stated.	knowledge, deatl ination and/or in	h occurre vestigation	d at the tim on, in my op	ne, date and pinion, deati	place, a	and due to the	cause(s) a date and	and mann place, and	er as sta d due to	ted. he cause(s)	
)	To the Ho within 24 P	Me	29b. Signature and title of certifier About	ule Syei		2	9c. License	number S O	01		29d, Date		Month, D	ay, Year) 2006	,
	6		30. Name and address of person who ABDUL ADJE!	3001 Sc	OUTH HY		リヒア	STRE	EET	BALTIY	nore	MA	RYLI	Mb 212	25
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 4 2006	32. Registrar's Sig	nature	2									

			For State Registrar	State of Ma	aryland / Dep		Health and M	ental Hygi	•	14008
	Phys	sician	1. Decedent's Name (First, Middle, La					2. Date of Death	1	3. Time of Death
	/Me	edical	Ruby Mae Hic	htower		4h Cily Town	or Location of Death	April 2	8, 2006 Year	12:59 PM
	Exa	miner	Upper Chesapeake		ontor	Bel Ai			Harford	1
	Fune		5. SociaTSecurity Number 6. S	ex 7. Age	e (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
	Direct	or	408-26-9646 Usual Residence of Decedent	- X	87 Yrs.			Feb. 6,	1919 Ten	nessee
	anyland Phow	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
159 pm	5-0036 72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f show dical Exercities must be notified at	Director	Maryland Harford	i	Bel Air	10f. Zip Code		10	ng. Citizen of What Cou	1 ☐ Yes 2 📉 No
5	h with	al Dir	1318 Gunston Roa	ad.		21015		10	USA	21 tu y :
3	ar deat	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?			Hispanic Origin? (Spe pan, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
7	0036 hours after turel; or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	lo	1 ☐ Yes 2 ☑ No	Specify:		Specify:	h i b c
	21215-0036 d within 72 hours af giene. In the maturel; or the Mudical Exercising	eted	15. Decedent's Education (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occu	pation during most of worki	10	6b. Kind of Business/li	hite ndustry
	within then then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of workingd)			
0		Be Co	17. Father's Name (First, Middle, Last))	Но	memaker_	18. Mother's Name		Own Home (aiden Sumame)	
00	ylar ould by Menta Arked	To E	Peter u/k	Cottel			Fanny.		/k u/l	
12810	Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: If Item 22 is marked oth my injury or other traumatic even in		19a. Informant's Name/Relationship (William C. Hight	**					City or Town, State, Zi	
3	Baltimore, Maper 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra		20a. Method of Disposition		20b. Place of Disp		1 0		Oc. Location - City or T	
7	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State (y)	1	Mem. Gard		/06 в	el Air, Ma	rvland
	Balt Departs mports	SDCs.	21. Signature of Funeral Service Licer	esee /	2	22. Name and Addre	ess of Facility Mo	Comas F	uneral Home	e, P.A.
	aug.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	phoations mat caused					don, Maryla	and 21009 Approximate
	Physicia	an l	shock, or heart failure. List onlyt Immediate Cause (Final disease or condition	Septi	a Shock	s due	to Right	- Midd	le Libe.	Interval Between Onset and Death
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56	60, be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence of):)	
33	0 0 0	edical		_ d						
#	Records, P.O. Box 68 The law requires that the death certificat the hes been signed by the attending phy age 2 should be detached for use as in	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnanc	v		23d. Date of deliv	*
	O. B. he death	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown		Other (specify)	,		Month	Day Year
7	ds, P.O. irres that the disigned by the dibe detached	by Ph	Part II. Other significant conditions of	contributing to death bu	It not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
igh tower	ecords, law requires t	ted b						1 🗆 Yes	2 No 3 Pro	bably 4 🗍 Unknown
7	Recor	Completed					· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
8		Cor	OS Mag annu referred to medical						Yes 1 ☐ Yes	2 🗆 No
土	of Vita Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpatie	int 3□ DOA Ott	26. Place of Death		nce 6 Other (Speci	fv)
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ナ	Division or Attending after death. Director: Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be	θ 20 ο Place of Injur	ry - At home, farm, s		Yes 2 No	8t Location (Stre	eet and Number or Rur	al Route Number
2	Div	Serti	4 Homicide determined	building, etc	. (Specify)	ireot, labiory, office		City or Town,	State)	ar riodio Nulliper,
2	Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	ledical ((Check or 2 Medical Exam	niner: On the basis of	examination and/or ii	th occurred at the til	me, date and place, a opinion, death occurre	nd due to the cau	use(s) and manner as set and place, and due t	stated. to the cause(s)
	To the within 2 To the complei	Med	29b. Signature and title of certifier	and manner sta	tea.	29c. Licens	se number	290	d. Date signed (Month.	Day, Year)
	F 5F 0) My	(h	. 0 .		45390	A	pril 29,	2006
	17		30 Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print)	Load # 2	00 Be	el Air m	221014
	S energy races	State	31. Date filed (Month, Day, Year)					-,	•	-
	Reg	istrar	MAY 0 4 21	006	r's Signature	20:52				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 26, Day 2006 Year **Physician** 7:15 p Edna F. Ivers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 940 Whispering Ridge Lane Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☐ F May 11, 1926 **Director** 116-18-4885 79 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at Harford Directo Md. Bel Air 1 Yes 2∑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 940 Whispering Ridge Lane 21015 U.S.A. Funerai 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiane. senior auditor insurance other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Hugh Ivers Mary Goehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret V. Ivers/sister 940 Whispering Ridge Lane, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 5/2/2006 E. Hanover, N.J. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee, 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic Immediate Cause (Final disease or condition **Physician** Linu Cuncer months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the attending physicien and hed for use as the burial-translt The law requires that the death certificate be executed Due to for as a consequence of: P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the al d be detached fo 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy rmeg? 2V No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, reath opcurred at the time, data and place, and due to the nause(s) and interior as stated. 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death obtained at the time, data and place, and due to the nature(s) and make the stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print) Ashkan Bahrani, M.D., 602 S. Atwood Road, Suite 200, Bel Air, Md. 21014 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 4 2006 Registrar

			1 - For State Registrar	State of Marylar		ent of H		lental Hy	giene	6 14010
	Physici	an	1. Decedent's Name (First, Middle, Last)		207111101			2. Date of De.		Year 3. Time of Death
	/Medic Examir	cal	James Jackson 4a. Eacility Name (If not institution, gives 54. AGNES H	treet and number)	4b. C	ity, Town, o	r Location of Death	Md	4c. County	OG 0500 M of Death
	Funeral Director		5. Social Security Number 6. Sex 218-86-2257		last birthday) If Un Yrs. Monti	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sept 5		9. Birthplace (State or Foreign Country) unk
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	,		83.818		10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Irector	MD Baltimor	e C	atonsville	Zip Code			10g. Citizen of W	1 □ Yes 28 No /hat Country? unk
5	'3-UU30 72 hours after deeth with the Marylar neturel', or Iteme 23a or 28a-1 ehow idical Examiner must be notified at	Funeral Director		12. Was Decedent Ever in U Armed Forces?		21228 cedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Blac	9 - American Indian, k, White, etc.
me	13-UUSO 72 hours after dee "neturel", or items	þ	1 Never Married 2 Marned 3 Widowed 4 ⊠ Divorced	1 ☐ Yes 2 A No If Yes, Give Year or Dates:	1 🗆 Ye:	s 2No	Specify:		Specify	white
Jame		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk	cation completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO Disab]	work done Tuse retired	during most of work	ing	16b. Kind of Bu	siness/Industry
_ 7	yiand A buid be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last)		DISABI	unk	18. Mother's Nam	e (First, Middle,		unk
ckson	Maryiand od 2 should be file lith and Mental Hy 27 Is marked oth	Ě	19a. Informant's Name/Relationship (Typ. St. Agnes Hospital		1		and Number or Rui			State, Zip Code)
Jack	Dallimore, Marylania ZIZ permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then any injury or other treumatic event, The Mance.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 4 Other (Specify)	20b. I emoval from State	Place of Disposition (cemetery, crematory	Name of	e. Baltimo	Date MD		City or Town, State
13 B	permit. I Depertm Importa any injur		21. Signature of Fundral Service License Ronald S. W	ne /	State		tomy Boar	d 655 W	. Baltim	ore Street
•	Physician /Medical Examiner		23a. Pakt 1. Enter the disease, or compile should be a compiled on the compile should be cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a consec	O j humas	node of dyir	ng, such as cardiac	deficien	rest,	Approximate Interval Batween Onset and Death When Years
02260	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
s you of a shapped left Vital Decision	the Hospital or Attending Physicien: The law requires that the death certification 24 hours elier death. The A hours elier death. The Eneral Director: After this certificate has been signed by the attending physicieny filled in by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 Live birth 2 Fete 4 Pregnant at time of c	el death 3 Ectopi		1		23d. Date Mor	e of delivery th Day Year
9	wrequires that the deben signed by the should be detached	<u>م</u>	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	ig cause giv	en in Part I.			ibute to the cause of death? 3 Probably 4 Inknown
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Vito	VILC Sicien: certific irector.	Be	25. Was case referred to medical examiner?	ospital:	/	DOA Oth	26. Place of Deat			
Č	g Phy g Phy er this	n: To	1 ☐ Yes 2 ☑ No ''' 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor	4 Li Nursing no		dence 6 Other	
i	r Attendin er death. rector: Aft	Certification:	1 Patural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	Injury M ome, farm, street, fac	1 🗆	Yes 2 □No	28f. Location (S City or Tov	Street and Numbern. State)	er or Rural Route Number,
Č	To the Hospital or Attending Physicien: The law within 24 burus eller death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examina	owledge, death occur	red at the tir	me, date and place,	and due to the	cause(s) and mar	nner as stated.
	To the I within 2. To the I complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		20c Linear	a sumbor		and Date since	
			30. Name and address of person who con	mpleted cause of death (Iter	π 23a) (Type, Print)	1) 2	77375	2		21229 Layland
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signal	Aure Angels	m/	grenue	TAID	nure 11	lay (hend

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend#5 Per FH g855 5/04/06 Contribute of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Yeer BERNICE APRIL 30 2006 6:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 09/17/1912 5. Social Security 0704 Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🗸 F Hours 93 212-12-97 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or itsms 23s or 28s-1 show other traumatic event, the Medical Exeminar must be notified at Director 1 ☐ Yes 2 🙀 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3420 WOODVALLEY DRIVE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: WHITE Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other thsn "n. Elementary/Secondary (0.12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SIMON GOLDBERG 2 ANNA **EPSTEIN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is m any injury or other traum EDWIN JULES / SON 8303 MARCIE DRIVE - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM: 05/03/2006 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 1000 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** netastatic Cancer unknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the th 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1□ Yes 2 No 2 No 1 ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No t 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00063534 .M. Shahbazi May ,1,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstown 21136 main street Shanba 2 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) KIDWELL Month Year M pril Physician DOROTHY 29, 2006 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll County Hospital West Minster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 28, 1925 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 ☐ XF 80 209-18-9882 Yrs Director Usual Residence of Decedent 10d. fnside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Modical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Owens Mill Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "netural", or Items 23a or. U.S.A. 21117 8715 Groffs Mill Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Tes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Zager Frank Maihen ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3671 Hooper Road, New Windsor, MD 21776 Charles Kidwell (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MayDate 5. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5 permit. Page Department of Importent: If any injury or once. Clinton, Maryland Resurrection Cemeterly 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licer 6633 Old Alexandria Ferry Road Clinton, MD20735 Mo1457 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBRO-VASCUL Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □ Ectopic pregnancy 1 Live birth Year in the past 12 months? Month Dav 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Completed by 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an 1 ☐ Yes ths Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 XNo this After this funeral of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No death. Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 . Helon, M.D. D0017695 April 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELCLY M.D. CARROLL HOSPITAL CENTER, WESTMINSTER; MD 21157

State Registrar 31. Date filed (Month, Day, Year)

4 2006

ABDALLAH J.HELCLYM-D 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		-	For State Registrar	Glate of Ime		ertificate	of Death		R	eg. No.	J	1 4 0 1	***
H	Physicia	an	1. Decedent's Name (First, Middle, L RONALD	ast)	KID	WEL	L	-	2. Date of Deal Month		Year	3. Time of D	P _M
	/Medic Examin	er	4a. Facility Name (If not institution, g Carrol County I	lospital	(In the local birth of	We	wn, or Location of est Mins Year If Under	ster	B. Date of Birth	4c. County of	11	place (State or I	Foreign
ct,	Funeral Director		5. Social Security Number 6. 214 68 8033 Usual Residence of Decedent	Sex 7. Age	6 (In yrs. last birthda 51 Yrs	Months D	ays Hours	Min.	(Month, Day Oct 22	, Year)	Сои	nington	
	72 hours after death with the Maryland Instural; or tiems 23s or 28s-1 show oreal Examiner must by modified at	tor	10a. State 10b. County Maryland Carrol	L	10c. City, Town or N	Location ew Winds	sor		-			1 ☐ Yes	
	with the	Directo	10e. Street and Number 3671 Hooper I	Poad		10f. Zip Co	ode 21776		1	10g. Citizen of W Unite			
_	ter death v	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		3. Was Deceder If Yes, specify	t of Hispanic Or Cuban, Mexica		cify Yes or No- lican, etc.)	14. Race Blac	e - Ameri k, White,	can Indian,	
2000	ours af	þ	3 ☐ Widowed XX Divorced	If Yes, Give Year or Dates:		1 Tes		:		Specify		Vhite	
7-6171	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural; or items 23s or 28s-f show event, the Madical Examination must be multiped at	Completed	15. Decedent's (Specify only highest (Secondary (0-12)	Education grade completed) College (1-4or to 5 to	(G iif	ecedent's Usual C live kind of work e. DO NOT use ctrical	done during mos	st of workin	g	16b. Kind of Bu		idustry	
yland z		To Be Co	17. Father's Name (First, Middle, La Charles I						(First, Middle, Majhe	Maiden Sumam			
Mary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship			ailing Address (5						p Code)	
	es 1 an of Heal f item 2 r other		Charles E. Kidwe	☐Removal from State	20b. Place of Di cemetery,	isposition (Name crematory or other ection	of er place) Ma	ay 5,0	2006	20c. Location - Clinton,	City or T	own, State	
Baltimore,	permit. Pag Department Important: I any injury o once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		01457	22. Name and	Address of Facil	lity Lee		l Home, inton, M		6633 02 20735	1d
	Physician		23a. Part1. En er the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	omphications that cause nly one cause on each li	d the death. Do not ine.			-		•		Approximate Interval Betwoonset and D	reen
68760,	Medical Examiner By physician and as the prival-transit	Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORC Due to (or as	a consequence of) a consequence of) a consequence of)	:	DIAL ERY «	Disc	BASE	,		YEAR	!5
P.O. Box 68	n requires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pred					ite of deli		'ear
	uires that signed b	by	Part II. Other significant condition	s contributing to death	but not resulting in t	he underlying car	use given in Part	l. 	23e. Did t	obacco use cont Yes 2 No	tribute to		eath? Inknown
Recor	The law req ate has beer page 2 shou	Completed	END-STAC	BE REA	NAL 3	BISEA	SE		24a. Was autor perfo 1 Yes	psy ormed?	Were au prior to death? 1 Yes	topsy findings a completion of ca	available ause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely titled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of beath 1 Natural 5 Pending investigs 2 Accident investigs 3 Suicide 6 Could no	ation	ury 28b. Tir	me of 28 ury M	Other: 4 N c. Injury at Work? 1 Yes 2	Nursing Hor	28d. Describe	one dence 6 □Oth how injury occur Street and Numb	rred		ber,
Ω	urs after or nrs after or nrs Directives		4 Homicide determin	building, s	etc. (Specify)			and place	City or To		anner as	stated.	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 2 Medical E	xaminer: On the basis and manners	of exa <i>m</i> ination and/ stated.	or investigation,	in my opinion, de	eath occurr	ed at the time,	date and place,	and due	to the cause(s	
)			A. J. He	to completed cause of	death (Item 23a) (T	ype, Print)	0001	769	5	April	28,	200,	6
	Ju a	0.10		ELOU, MD	trar's Signature			COVIL	RUB	THINSIE	RI	40211	7
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician ETHEL CAREN KIRKLAND 2005 2:38 P M APRIL 30. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9039 SLIGO CREEK PARKWAY, #1608 SILVER SPRING MONTGOMERY 8. Date of Birth (Month, Day, Year)
OCT. 22, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 80 104-18-3732 Director 1925 NEW YORK Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow item 27 is marked other then "naturel", or iteme 23a or 28e-f ehos other treumatic event, the Michigal Exteninar must be notified at 1 ☐ Yes 2 XNo MARYLAND ANNE ARUNDEL CROWNSVILLE Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1018 DOCKSER DR. 21032 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ģ Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 permit. Pages 1 and 2 should be file Depertment of Health end Mental Hy Important: If Item 27 is marked other eny injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be SAMUEL FREISTADT FANNIE LANDSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9039 SLIGO CREEK PARKWAY, #1608, SILVER SPRING, MD BONNIE KIRKLAND / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MAY 2, 1 □ Borial 2 X Cremation 3 □ Removal from State METRO CREMATORY, INC. CATONSVILLE, MARYLAND nation 5 10ther (Specify) 4 🗆 Dk 2006 21. Signat of Funeral Service Licensee 22. Name and Address of Facility
KIRKLEY-RUDDICK
FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21U61 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Olon **Physician** Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by I should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed certificete 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughteris Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA ş completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: : After 5 Pending investigation 1 Natural death. М 1 TYes 2 No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a To the Funerel 6 Two Certifying Physician: To the bast of my knowledge ceath conured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier may 1, 2006 D52830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Werner 900 Bestgate Road #300, Anneyolis, MD 21401 Deanine

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 0 4 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32 legistrar's Signature

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				ne (First, Middle, La	st)								2. Date o				3. Time of Death
	Physici		G.	enevieve		М.	Kuchta						Month May		Day 2006	Year	1:15 a ^M
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	Funeral		5. Social Security I				e (In yrs. last	birthday)		oche	If Under	24 Hrs.	8. Date o	f Birth			place (State or Foreign
	Director		215-16-20	057	☐ M 2K	F	84	Yrs.	Months	Days	Hours	Min.	(Month	7, Day, Y	1921		vland
			Usual Residence				-04						oury	23,	1721	Har	yrand
	ehow		10a. State	10b. County			10c. City, T	own or Lo	cation							1	10d. Inside City Limits
	Mar	ţō	MD	Baltim	ore				Pike	evil	16					i	1 ☐ Yes 2X No
	288 DOM	Je C	10e. Street and Nu						10f. Zip					100	. Citizen of	What Cour	ntry?
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	na 2	Funeral Director	11. Marital Status		,		Ever in U.S.	13. \	Nas Dece			gin? (Spe	ecify Yes o	r No-	14. Rac	ce - Americ	
10	ther of the control o	F		ried 2 Married		ed Forces? ∕es 2√21	10	'	f Yes, spe	cify Cuba	n, Mexicar	, Puerto	Rican, etc.	.)	Bla	ck, White,	etc.
21215-0036	within 72 hours after death with the Maryland ane. than "natural, or itema 23a or 28a-f ehow ia Mudical Examirar must be notified at	<u>ک</u>		4 Divorced	If Ye	s, Give or Dates:			1 ☐ Yes	20 No	Specify:				Specif	y: W	hite
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an	d be ental	o Be	1	Francis		Plogm	an					Mar	ian	Mac	Dona1d	1	
Σ	d Me	2	19a Informant's N	lame/Relationship (9h Mailir	n Address	(Street	and Numbe				City or Town,		Code)
Maryland	d 2 s th en 7 ie trau		Adam J.	, ,					-								(0000)
	1 an Heal Heal ther		20a. Method of Dis		Husba	iid	20b. Place		andal		enue		esvi Date	7777	MD 2 oc. Location		num State
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Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health end Mental Hygiene. Important: if Item 27 ie marked other than "natural", or itema 23a or 28a-f ehoven ply lojury or other traumatic event, ital Mudical Experiment must be notified at anno.		21. Signature of F	uneral Service Lice		2	ν	22	. Name ar	nd Addres	s of Facilit	y R	eiste	erst	own,MD	21	136
_	20 = 0		Sie	phen	,,,	ewi	Sun	E	Line	Fune	ral H	ome	1182	24 R	eister	stown	n Road
			23a. Part1. Enter shock, or he	the disease, or com art failure. List only	plications I one cause	hat caused on each lir	the death. D	o not ent	er the mod	e of dyin	g, such as	cardiac o	or respirato	ry arres	t,		Approximate Interval Between
4	Physician		Immediate Cause disease or conditi		F	Hner	OSCIE	rot	6 0	9:2	1000	9516	1100	DI	SPAS	e	Onset and Death
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V	uted d ansit	Examiner	Cause (Disease of that initiated event	r injury													
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68760,	ertificate be executed ding physician and se as the burial-transit	Medical		5-32	u												
×	9 7 8		IF FEMALE: 23b. Was deceder	at pregnant	23c. If yes	s, outcome	of pregnancy								23d Da	ite of delive	arv
Bo	ette	cia	in the past 12	2 months?			2 Fetal death time of death		Ectopic pr Other (sp							onth	Day Year
P.O.	y the c	Physician	9 Unknow			Jnknown				,,							
	Physicien: The law requires thet the death cer this certificate hes been signed by the ettendir ral director, pege 2 should be detached for use	/ P	Part II. Other signi	ificant conditions	ontributing	to death bi	ut not resultin	g in the ur	nderlying o	ause give	en in Part I.		23e. i	Did toba	cco use cont	tribute to th	ne cause of death?
of Vital Records,	signe d be	d by								_				I ☐ Yes	2 🗆 No	3 ☐ Prot	ably 4 3 tonknown
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Division	ar de	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e.	Place of Inju	ry - At home, . (Specify)	, farm, str	eet, factory	, office		:	28f. Locati	on (Stre	et and Numb	er or Rura	I Route Number,
Ö	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification;				Janasig, Ott	. (Opociny)						Ony or	70447,	olalo)		
	nour nour ners y fille		29a. Certifier	12 Certifying Pt	ysician: T	o the best of	of my knowled	dge, death	occurred	at the tim	e, date an	d place, a	and due to	the cau	se(s) and ma	anner as s	tated.
	• Hc • Fu • Fu	edicai	(Check only one)	2 Medical Exa	niner: On i	he basis of manner sta	examination	and/or inv	estigation/	, in my op	inion, dea	th occurr	ed at the ti	me, date	e and place,	and due to	the cause(s)
	roth rothic somp	Ž	29b. Signature and	d title of certifier					290	. License	number			290	I. Date signe	d (Month,	Day, Year)
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06-02952 Joseph N. Kuhn

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State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ertificate of Death	, ,	2006 a. No.	1401.
Physici edical Exami		Decedent's Name (First, Middle, Last) Joseph Nicholas Kuhn		2. Date of Death Month	Day Year	3 Time of Death 2116 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	May 1, 200 ath	4c. County of Death	
		Harbor Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs.)	Baltimore City Isst birthday) If Under 1 Year If Under 24th	In To Date of Date	(MM/DD/YYYY) 9. Bird	
Funeral Director		220-11-2789 X M 2 F 36	· —	9-21-	Foreign	
ží.		Usual Residence of Decedent	y, Town or Location			
b war	L		1timore City			10d Inside City Limits 1 X Yes 2 No
farylan 28a-fs Latono	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Cour	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If liem 27 is marked other than "natural", or items 23a or 28a-f show any rother traumatic event, the Medical Examiner must be notified at . nce.		7 N. Kresson Street	21224		USA	
eath wil	Funeral	11. Marital Status 1 Married 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14 Race - Ameri White, etc.	can Indian, Black,
after de al", or ner mu	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Wh	ite
hours natur	ted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r	of work done retired)	16b. Kind of Business/I	ndustry
036 thin 72 ne. • than '	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Roofer		Constru	ction
15-0(filed wi Hygier d other the M	Cor	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	aiden Surname)	
212' uld be uld be mental marke	o Be	Joseph Marion Kuhn 19a Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of	ria Morw		Zin Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	1	Joseph M. Kuhn - Father	7 N. Kresson St.,	Baltim	ore, MD 2	1224
Ore, se I an of Hea If iter		20a. Method of Disposition 20b. 1 Burial 2 Cremation 3 Removal from State	. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
Itim	3	4 Donation 5 Other Specify: B a 21. Signature of Purieral Service Lipensee	ayview Crematory 5	-3-06	Baltimor	e, MD
Perm Perm Depty Imp		Cathakit -	PA, 2134 Willo			
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
≒xaminer		Immediate Cause (Final disease or condition resulting in death) Let of Cor as a consequence of the correction of the co	of):			Death
and the second second	L	Sequentially list conditions, b				
	miner	if any, leading to immediate cause. Enter Underlying Cause (Clis os or him) that nitigated c.	of):			
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8760, ificate be g physici s the buri	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Live birth		mancy	23d. Date of delivery Month D	eu Voes
Box 68's death certification at the attending ed for use as it	Physiciar	4 Pregnant at time of d	2	inancy	I Working D	ay Year
O. Bo at the de d by the stached fo	Phy	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
b, P.O. irres that the signed by the detache	d by			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
Records, The law require	Completed			24a. Was an autopsy	prior to ci	opsy findings available ompletion of cause of
tal Recrian: The Lecrificate h	Com			perform 1 V Yes 2		s 2 No
Vital Rechysician: The Inthis certificate Indirector, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	26 Place of Death (Check Place of Death (Check Place) 26 Place		esidence 6 Other:	
Division of Vital tal or Attending Physician: rs after death al Director: After this certicled in by the funeral director	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?		w injury occurred	
ision Attend r death ector: by the f	catio	2 Accident Investigation	1 Yes 2 No			
Divis Hospital or A 24 hours after Funeral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	home, farm, street, factory, office building, etc.	or Town, Sta	reet and Number or Rur ite)	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place, an			
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
	-	The 1174 -	O.C.M.E.		May 2, 2006	, 50, , 00,
		30. Name and address of person who completed cause of death (Iten	·			
	tate	Theodore King MD. Assistant Medical Examine 31. Date filed (Month, Day, Year) 32. Rejistrar's Signat		21201		
St Regist		MAY 0 4 2006	K. Book			

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Clarence Landon State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 29, 2006 **Medical Examiner** 1628 hrs ARENCE E DWARD JK 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1520 West North Avenue Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or Months Days Min Director Hours Country) MARVLAND 1 X M 2 5-24-1415 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d Inside City Limits s 23a or 28a-f show r notified at once. 1 X Yes 2 No rmit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiest partment of Health and Mental Hygiest than "natural", or items 23a or 28a-f she purst article 27 is marked other than "natural", or items 23a or 28a-f she pury or other traumatic event, the Medical Examiner must be notified at once ury or other traumatic event, the Medical Examiner must be notified at once MARYLAND Director 10e. Street and Number Citizen of What Country NORTH ST AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes If Yes, Give Year 3 Widowed 4 Divorced Yes 2 No specify. Specify: BLAC ģ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 ++GRADE MONPAWIN 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be ARENCE BOLDEN MARTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 crematory or other place) Removal from State Donation 5 Other Specify: 22. Name and Address 21. Signature of Funeral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Arteriosclerotic cardiovascular disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of). nause. Entire Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Dav Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the att be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Diabetes Mellitus 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate Yes 2 V No 2 No Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other 4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ို 1 🗸 Yes ٦No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred .s after dea. ral Director: At hy the fi 1 V Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within ... 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME May 2, 2006 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. egistrar's Signature 31. Date filed (Month, Day, Year) MAY 0 4 State

Registra

06-02624 Please Type or Print in Black Indelible Ink Hartley Letron Lee State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 18, 2006 Medical Examiner HARTLEY LETRON LEE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12627 Laurel Bowie Road Prince George's Laurel 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 23 Months Days Min. Hours 08/02/1982 Director 213-02-7964 1X M 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location MD. Prince George's Laurel 28a-f show 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8802 Hunting Ln. # 102 20708-1254 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 White, etc. Yes Widowed Yes 2 X No specify: Divorced Yes, Give Year "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. College (1-4 or 5+) marked other than ' 12th Electrician 17. Father's Name (First, Middle, Last) Hartley Be Lee Hannah 19a. Informant's Name/Relationship (Type, Print) If item 27 is m ther traumatic Hannah McClorin, Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date rtant: If it 1 X Burial 2 Cremation 3 crematory or other place) Removal from Stat 04/27/2006 Harmony Mem. Park Donation 5 Other Specify 21. Signature of Funeral Service Licer 22. Name and Address of Facility **Physician** failure. List only one cause on each line. /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit cal UNPENDED the attending physician ned for use as the burial -AMENDED Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown signed by 1 be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed certificate has been sector, page 2 should 24a. Was an autopsy performed? ✔ Yes 2 No 25. Was case referred to medical director, 26.Place of Death (Check only one) Be examiner? Other-After this Innatient 2 ER/Outnatient 3 DOA 1 Yes ٩ 28a. Date of Injury FOUND: Toy, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' Subject shot 1 FOLIND: Natural Pending Yes 2 V No

Black 16b. Kind of Business/Industry Private 18. Mother's Name (First, Middle, Maiden Surname) McClorin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8802 Hunting Ln. #102 Laurel, MD. 20708-1254 20c. Location - City or Town, State Landover, MD. Bianchi F.S. 814 Upshur ST. NW Washington, DC. 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 1 Yes To the Hospital or Attending Physician: within 24 hours after death. Nursing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred neral Director: 2 Apr 18, 2006 0213 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 12627 Laurel Bowie Road, Laurel, MD determined (Specify) Parking Lot To the Funeral 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 20, 2006 0 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIĞINAL **OCME 2006**

0230 hrs

10d. Inside City Limits

1 X Yes 2 No

Country) MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item #19a Per Fh C855 5/10/06 JH Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 25, Day 2006 Kenneth Lang, Sr. 11:05AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Southern Maryland Hospital Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug • 22 , 1919 Birthplace (State or Foreign Country)

L 7. Age (In yrs. last birthday) 5. Social Security Number XXM 2□ F 020-12-9985 86 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No Maryland Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4900 Cleveland Court 20748 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 1941-1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐Widowed 4 ☐ Divorced 1964 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) SMSGT Retired US Air Force 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Johnson David Raymond Bertha 19a. Informant's Name/Relationship *(Type, Print)*Carol **Strawy** (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4900 Cleveland Court Temple HIlls, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) May Bate 20c. Location - City or Town, State 20a. Method of Disposition 1 Daurial 2 Cremation 3 Removal from State 2006 Arlington Natioanl Cem. Arlington Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Lig-6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show solcal Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural, or item
any or other traumatic event, the Medical Examinar

Baltimore, Maryland 21215-0036

death

Director

Completed by Funeral

Be

2

Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATherosclerotic Cardio Visilan Ni Seene Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) _ 9 Unknown 9 🗌 Unknown

attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical detached ğ Completed Certification: death. after death within 24 hours a To the Funeral C Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Onset and Death

Day

1 Yes 2 No

25. Was case referred to medical examiner 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

autopsy performed?

2 2 No

27. Manner of Death 1 Natural
2 Accident investigation 6 Could not be determined 3 Suicide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 - Homicide

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D453 65 29d. Date signed (Month, Day, Year)

Sidazous 31. Date filed (Month I

32. begistrar's Signature 1 308:548-0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		Please	Type or Prin					•	_	ole.
	1 - For State Registrar		State of Ma	•	epartmen C <i>ertificat</i>			_	Reg. No.	5 14021
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/Medica Examine	A F. Mr. Nier	e (If not institution, giv	re street and number)	-1	4b. City,	Town, or Loca	_		4c. County	of Death Himore
Funeral	5. Social Securit	y Number 6.5	Sex 7. Ag	OU e (In yrs. last birth			Under 24 Hrs.	8. Date of Bir (Month, Da	th Yang)	9. Birthplace (State or Foreign
Director	201-18- Usual Residence		1 X 2 □ F	77 Y	rs. Months	Days Ho	ours Min.		20 1928	PA
show	10a. State	10b. County		10c. City, Town	or Location					10d. Inside City Limits
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13a or 2	=	alther Blv	d.		101. Zip	212	234		USA	
ar deat	11. Marital Statu		12. Was Decedent Armed Forces?		13. Was Deced	dent of Hispan cify Cuban, Me	nic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	14. Race Black	- American Indian, c, White, etc.
) SS 8 9 1	3 ₩ Widowe	larried 2 Married d 4 Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	NO	1 🗆 Yes	21 <mark>x</mark> No Sp	ecity:		Specify:	white
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212 212 giene.	Elementary/S	econdary (0-12)	College (1-4or t n/a	0+)	Vice Pr				ACME	Food Store
Iryland 212: should be filed within to Mental Hygiene. marked other than imatic event, the Mental Hygiene.	17. Father's Nar	me <i>(First, Middl</i> e, <i>Last</i> Edward I	•					e (First, Middle, tterson	, Maiden Surname	э)
Maryla Maryla to 2 should lith and Men traumatic.	_	s Name/Relationship			_	(Street and N	Number or Run	al Route Numbe	er, City or Town, S	
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Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe once.		f Funeral Service Lice		Saters	United 22. Name ar	d Address of	Facility		-	
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Division of Vital Records, for Attending Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.		eath	28a. Date of Inju			28c. Injury at Work?			how injury occurre	
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Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certilicate he completely filled in by the funeral director, page	29a. Certifier (Check only one)		miner: On the basis of	f examination and	or investigation		n, death occur		date and place, a	
To the Hos within 24 hr To the Fun completely	29a. Certifier (Check only one) 29b. Signature	2 ☐ Medical Exa	miner: On the basis of and manner st	f examination and ated.	/or investigation	, in my opinior	n, death occur		date and place, a	nd due to the cause(s)
To the Hos within 24 hr To the Fun completely	29a. Certifier (Check only one) 29b. Signature	2 ☐ Medical Exa	miner: On the basis of	f examination and ated.	/or investigation	c. License nur	n, death occur		date and place, a	nd due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Lee 28-2006 12:16 AM /Medical City, Town, or Location of Death Facility Name (not institution, give street and number) 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Cay, Y9928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours 243-36-1014 1 M 2 F Months Days Director Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 la marked othar than "natural", or Itams 23a or 28a-1 show other traumatic avent, It a Medical Examinan the molified at Baltimore 1 Yes 2 □ No MD Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21216 or Itams 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1□Yes 2KNo Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use tetired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Eather's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 11:am Jane 19b. Mailing Address (Street and Number mant's Name/Relationship (T Route Number, City or Town, State, Zip Code) want: If itam 27 la 20b. Place of Disposition 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State ure if Furieral Service Licens neral Services llstown MD 21133 23a. Part1. Entering disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Cardiothrombotic **Physician** e rest /Medical Due to (or as a consequence of): Examiner curdiovascular urtheroscherotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

↑□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Year Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 34b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No or Attending Physician: in by the funeral director. 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 atural after death. 1 ☐ Yes 2 ☐ No 2 T Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide filled within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO057465

DHMH 17 Rev 1/2001

State Registrar yap aneno

N.S. RAYADA / SE SUD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Segistrar's Signature

25 Maig St, Snik 200 Reisterstown

	Pleas	e Type or Print in Black I	ndelible Ink. Ensure A	All Copies A	re Legible.			
	for State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygie	Z U U O	4023		
Physician /Medical		^{Last)} Milton Melvin Maeser	., Jr.	2. Date of Death Month May 3, 2	Day Year 006	3. Time of Death 8:45 A M		
Examiner	4a. Facility Name (If not institution,		4b. City, Town, or Location of Deat	h	4c. County of Death			
		st Center	Towson	10.0	Balti			
Funeral Director	217-22-5318	i. Sex 1 M 2 F 7. Age (In yrs. last birthda 76 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	ear) Coun	lace (State or Foreign try) yland		
and	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		1	Od. Inside City Limits		
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21215-003 ed within 72 hours ygiene. ner than "natural; it, it a Mudical Ext	15. Decedent's (Specify only highest	Education 16a Dec	cedent's Usual Occupation ve kind of work done during most of wo	rking 16i	b. Kind of Business/Inc	dustry		
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Box auth cert attendin for use	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	B Ectopic pregnancy		23d. Date of delive	,		
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i: The cate he cate he com		n disense	/	performed 1 ☐ Yes 2	d? death? No 1 ☐ Yes	2 🗆 No		
Division of Vital Revalence of Attending Physicien: The target death. Director: After this certificate hes in by the funeral director, page 2 ertification; To Be Compertification: To Be Comp	examiner?	Hospital:	Cthon	ath (Check only one)		11		
Physical drawn of 1. To 1. To	1 Yes 2 No	1 Inpatient 2 EH/Outpat	Helit 30 DOA 40 Nursing F	10me 5 Residence 28d. Describe how	e 6 Other (Specify	MOSPICE		
on dring th.: Afte fune	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year) Injury			,-,,			
Atter dea octor by the	3 Suicide 6 Could no	t be 28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (Stree	et and Number or Rura	l Route Number,		
Division c tal or Attending P rs after death. el Director: After ti ed in by the funera Certification;	4 ☐ Homicide determin	building, etc. (Specify)		City or Town, S	State)			
Division of To the Hospital or Attending Physical Attended to the Funarel birector: After this completely filled in by the funeral dimension of the Attended to the funeral dimension of the Attended to the		Physician: To the best of my knowledge, de ceminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)		
o the carbination of the carbon t	29b. Signature and title of certifier	A . A	29c. License number	29d.	Date signed (Month,	Day, Year)		
+ 3 + 0	M Anth	my Kily, in	025205		MAY3,	2006		
4	30. Name and address of person w	no completed e of death (Item 23a) (Typ	e, Print) 6601 N. CH	ARLES STR	EET			
V	W.H.K.12	7	TOWSON, 1	MD ZIZO	24			
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature						
Registrar DHMH 17 Rev 1/2001	MAY 0 4	2006	10:62	=				
DINNIT 17 Nev 1/2001		ORIG	GINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 April 27, **Physician** Mc Haltie 1810 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Aug 19, 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**⊠**M 2□ F Min. Year) 1951 54 Yrs. Director 220-21-5007 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or Itams 23a or 28a-1 show 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-1 shov other traumatic event. It a Mudical Examinar must be multified at Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 110 Brightwater Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Givd Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) re kind of work done do DO NOT use retired) during most of working Private Elementary/Secondary (0-12) College (1-4or 5+) Security Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 Is marked any injury or other traumatic ev 900s. Donald McHattie unk Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barabra McHattie/Wife 110 Brightwater Road Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 2006 MD ` 4 ☐ Donation 5 Other (Specify) VIEW CREMATORY altimoRE 21. Signature of Funeral Service Licensee 22. Name and Address of acility
Miller's Metropolitan Chapel 1922 Forest Drive Annapolis, MD P=11 Enter the disease, r mpile a ns that shock, or he illure. List only one cause in Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): trict 5-03-1 >2d /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Entail of Janying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death M 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 KNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Diractor: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24504 plein vin

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

AAMC

32. Registrar's Signature

Annylic NiD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

W1)

State of Maryland / Department of Health and Mental Hygienie 14025 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** MILDRED IONA MATTHEWS April 26, 2006 7:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll 21 Timber Ridge Drive Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min Months Days Hours 1 M 2 T F Nov 9, 220-05-0907 1920 Director Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 21 Timber Ridge Drive Funera 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎝 ☐ No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Md. Paper Box Co. Press and Office Worker 0 treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental H William Matthews Florence Messick ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 s' ,/ Health ar // item 27 i Barbara Snyder (Niece) 1215 Weddel Avenue, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department of Important: If I eny injury or Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4/29/2006 21. Signature of Fun-al Serve Lice see Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CO DO MAN ears /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, physicien Physician/Medical the ettending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the e 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an page 2 s has certificate 1□ Yes 2/1 No director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) ို 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Natural 2 Accident 5 Pending Injury s efter dec. rai Director: Alte 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e 29a, Certifier 🗱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print) 30. Name and address of p FRE State Registrar 2008

Rodreco D. Murray 06-02893

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene UNK UNK 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 29, 2006 1539 hrs Medical Examiner Rodreco D. Murray 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Linthicum 5199 Raynor Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Months Days Hours Min May 13 1978 Director 214-92-0119 $27_{\rm Yrs}$ 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location in y 10a State Yes 2X No Anne Arundel Severna Park 28a-f show 1ary1and permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 21146 USA 835 Manhattan Beach Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married Yes Black f Yes, Give Year or Dates: 1 Yes 2X No specify: Specify Divorced 3 Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Self Employed Construction Worker 11th 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn L. Eldridge Be Harry L. Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1299 Ashton Ct. Apt. 3B Annapolis, Md.21403 Layshawn Fisher (Cousin) 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Bestopat ece 1 X Burial 2 Cremation 3 Removal from State Memorial Park 5-6-06 Annapolis, Md. 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Reese & Sons Mortuary, P.A. West St. Annapolis, Md. 21401 Wm. 821 Zavry H, Ress Moc483 1821 West St. Annapolis, Md.

23a. Part I. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED physician the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown requires that the 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available this certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient Residence 6 🗸 Other Scene Nursing Home 5 ER/Outpatient 3 DOA 1 🗸 Yes ၉ 28a. Date of Injury (Month, Day Year) Apr 29, 2006 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work' After 27. Manner of Death Certification: Subject shot 1525 hrs Natural 1 Yes 2 V No 5 Pending within 24 hours after death To the Funeral Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be 3 Suicide or Town, State) 5199 Ravnor Drive, Linthicum, MD determined (Specify) Ground 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) O.C.M.E April 30, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) MAY 0 4 2006 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. erff,৩৪১১,১/২১/৩০ া। State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 28, Day 2006 Year **Physician** Willie Mae Moncrief 1:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Fort Washington Hospital Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16,1937 5. Social Security Number 9. Birthplace (State or Foreign Days Hours Min. 1 □ M 2(X)F 427 74 5997 69 Yrs. Mississippi Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b County 10d. Inside City Limits 1 ☐ Yes XX No MS Lawrence Newton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Velma Moore Road 31336 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A. Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed X X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Retired Retired 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Willie Munerief Moncrief Lettie Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15955 Pointe Meadow Court, Brandywine, MD 20613 Carvis Moncrief (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 5, 2006 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Altare Cemetery May 6, 2006 * 4 ☐ Donation 5 ☐ Other (Specify) Newton, MS 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 1 Hran m00257 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBROVASCULAR disease or condition resulting in death) Due to (or as a consequence of): ACCELERATED MERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ABETES MELCITUS 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

attending physician and for use as the burial-transit

the

s after dec...ral Director: After ...

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Be

P

Certification:

Medical

State Registrar

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Marical Examinar must be notified at

2 should be filed within 72 hours after c and Mental Hygiene. Is marked other than "natural", or Iten

Pages 1 and 2 st ment of Health and ant: If Item 27 is s

permit. Page Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0036

with the Maryland

24a. Was an

autopsy performed 2No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

FORT WASIBINGTON MD 20744

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Tes 2 No

27. Manner of Death

1-12 Natural

2 Accident

4 Homicide

3 Suicide

29a, Certifier

29c. License number

Rd

29d. Date signed (Month, Dav. Year)

050086

128/2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 Could not be

determined

28a. Date of Injury (Month, Day Year)

VICTOR HERRY 11701 LIVINGSTON

31. Date filed (Month, Day, Year) MAY 0 4 2006

32. Paistrar's Signature

	•	For State Registrar	State of Mar		artment ertificate				iene () ()	6	40	28
Physici /Modic		Decedent's Name (First, Middle, Last, Spencer Marcus Mar.)						2. Date of Death Month May 2 2	Day	Year	3. Time of 8:55	Death a. ^M
/Medic Examin		4a. Facility Name (If not institution, give Somerford Place		Via ura la at historia.	Colum	bia	Location of Dea		4c. County Howard	1	on /State o	r Foroige
Funeral Director		5. Social Security Number 076-10-1784 Usual Residence of Decedent	TM 2∏ F	(In yrs. last birthday Yrs.		Days	Hours Mir			Engla	ice (State or y) ind	Poreign
Maryland	ctor	10a. State 10b. County MD Howard		10c. City, Town or 1 Columbia	ocation					100	d. Inside Cit 1 ☐ Yes	
th with the 23a or 28	Funeral Director	10e. Street and Number 8220 Snowden River	Pkwy		10f. Zip (210			10	0g. Citizen of V USA	Vhat Countr	y?	
urs after dea ni', or Iteme	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 □X es 2 □ No If Yes, Give Year or Dates:		. Was Decede If Yes, speci	rfy Cubai	spanic Origin? (n, Mexican, Pue Specity:	Specify Yes or No- into Rican, etc.)		e - America ik, White, et : Whi	tc.	
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: it item 27 is marked other than "natural; or iteme 23a or 28e-f show says injury or other traumatic event, the Medical Examinal must be notified at ODCs.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+	(Giv	edent's Usual re kind of work DO NOT use	k done a	luring most of w	orking	onsulti		stry	
ild be filed v lental Hygie ked other t lic event, to	To Be Co	17. Father's Name (First, Middle, Last) Hyman Marlow	4	CFA			18. Mother's Na Mable H	ame (First, Middle, M				
and 2 shou ealth and M n 27 is mar nar traumat			upe, Print) aughter	9353	Corns	hock		Rural Route Number, Columbia	, MD 21	L045		
t. Peges 1 tment of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		Metro Cr	ematory or other	her place Y	05/	04.06 C	20c. Location - atonsvi	ille,	MD	
Departiment important		21. Signature of Funeral Service Licens MOy 23a. Part1. Enter the disease, or comp					-	mes, INC Road, Col			.045	
Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line),				PISEASE			Interval Bety Onset and D	
ate be executed tysicien and he burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
The law requires that the death certifica ate hes been signed by the ettending pl page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (sp. 9 ☐ Unknown					Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		Year
juires that t n signed by uid be detac	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					en in Part I.	23e. Did tobacco use contribute to the cause of deat				
The law require ate hes been si page 2 should b	Completed	24a. Was autop perior 1 □ Yes										
yeiclan: is certific director,	Certification: To Be (25. Was case referred to medical examiner? 1 Yes 2 No					26. Place of Death (Check only one) OA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No			(10	177 W(
pital or Att burs efter d eral Direct									ber,			
To the Hospital or Attending PP within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	Medical		inar: On the basis of and manner stat	examination and/or	investigation,	in my o		curred at the time, d	ate and place, 9d. Date signe	and due to	the cause(s	
150		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	e, Print) 3333	N. (ALVERI	sr#3	25, 61	htro	NE, M	φ
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 4 2	32. Registra	r's Signature	Carles						Ø	- ل ۵

Amend Item 23e per Dr., G852, U5/10/06dhb Reg. No. 1 - For State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAPAY **Physician** 2, 2006 2:00PM Mary Μ. McKernan /Medical 4c. County of Death 4a. Facility Name (If not igstitution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death Examiner Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 E Yrs. 46 Director April 8, 1960 212-50-2274 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Baltimore Lutherville Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 310 Felton Road 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status illed within 72 hours atter de la Hyglene.
I Hyglene.
other then "neturel", or item Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care Elementary/Secondary (0-12) College (1-4or 5+) Director Management Co. h and Mental Hygier 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be Pages 1 and 2 should be intentional beat of Health and Mental I C. 2 Miller Margaret Corroum Α. Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 310 Felton Road 21093 Lutherville, MD McKernan Husband Dennis G. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) South Carroll Crem May 3, 2006 Winfield, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee Reisterstown, MD | Eline Funeral Home 21136 Uni 23a. P. nt. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final disease or condition resulting in death) RENAL FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and tor use as the burial-transit PNEUMONIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2X No 3 Probably 4 Unknown as been signal Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ATRIAL ARRYTHMIA has performed? 1□ Yes 2 No this certificate or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М deeth. investigation Director 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide within 24 hours e To the Funeral I 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and clade, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05-03-06 D3Ø263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) кноо, FRANCIS TAT-TEE M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) gistrar's Signature State MAY 0 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 5-1-2006 02:15 PM Milton Frank Markowski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Severna Park Genesis Eldercare Severna Park If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10-22-1917 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F ΜĎ 88 217-05-5277 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. Count r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2x No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 U.S.A. 5801 Ritchie Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 AYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: white Specify: If Yes, Give Year or Dates: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other treumatic event, Ite Macalogue. Elementary/Secondary (0-12) College (1-4or 5+) Printing Lithographer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen (unknown) Thadius Markowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 258 Shakespeare Drive; Severna Park, MD 21146 Mrs. Lorraine Fiehn / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 5-6-2006 Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service License 1 Second Ave SW; Glen Burnie, MD 21061 MO1357 and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myocardia Physician resulting in death) /Medical Due t (or as a consequence of) Examiner local 40 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed emutur resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4. Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 250 No 1 Yes certificate : After this certifical funeral director, I Attending Physicien: 26. Place of Death Check on one 25. Was case referred to medical Be examiner Other: Hospital: 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 28d. Describe how injury occurred 27. Manner of Teath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide To the Hospitel or within 24 hours a

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completely filled 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2108 D, Dongto -CLACE ATE EYNTLDO 32 egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 4 2006 MAY O

			1 - State Registrar	State of Marylar				ealth and I D <i>eath</i>	-	giene Reg. No.	006	14031
			1. Decedent's Name (First, Middle, Last)						2. Date of De	ath	V	3. Time of Death
	Physici /Medic		William		N	Morri	.s		Month Mav	Day 1	Year 2006	4:30 P M
)	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, or	Location of Death	,	4c. C	ounty of Death	
			1317 Rippling Cour	t			Bur				ne Arun	del
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2□F 72		If Unde Months	or 1 Year Days	If Under 24 Hrs. Hours Min.	(Month Da	th y, Year)	9. Birth	place (State or Foreign
ш	Director			72	Yrs.				2-19-1	.934	MD	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	f sho	0	MD Anne Arun	del Gle	n Burn:	io						1 □ Yes 2 □ No
	the 1	Jec.	10e. Street and Number	dei die	n Dulii.		p Code			10g. Citize	en of What Cou	Λ.
	3a or		1317 Rippling Cour	t		21	.061			US		,
	Jeath Tre 2:	era		2. Was Decedent Ever in U	.S. 13.			spanic Origin? (S n, Mexican, Puert	pecify Yes or No		I. Race - Ameri	can Indian,
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens, and Mental Hygiens is marked other than "naturel; or items 23s or 28s-f show aumatic event, the Medical Examinar must be notified a	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates:		lf Yes, sp 1 □ Yes		n, Mexican, Puert Specify:	o Rican, etc.)	i	Black, White, Specify: Whit	
Ŏ	2 ho	Completed	15. Decedent's Educ		16a. Dece	dent's Us	al Occupa	ation	dia -	16b. Kind	of Business/In	dustry
2121	within 72 ene. than "nel	g	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired	turing most of wor)	King			
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פר	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						ne (First, Middle,		umame)	
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Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.	8 9	19a. Informant's Name/Relationship (Typ		1			and Number or Ru				•
e,	1 and Healt em 2 ther		Mrs. Elizabeth J.		131 / Place of Dispo	Ripp sition (Na	ling	Court,	Glen Bur	nie.	MD 2106 ation - City or To	1
altimore,	Pages nent of intentional		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State	semetery, crer	matory`or	other place	· 1				
들	it. Purtme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Fervice License					ion May				
Ba	Depa Impo eny i		The signal of the closures					Funeral			d Ave,	
			23a. Parti. Enter the disease, or complic	ations that caused the deat							illite, r	Approximate
	Dhusisian		shock, or heart/failure. List only one Immediate Cause (Final	e cause on each line.	11	>		,	Λ			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	01	att	141	Accol	e		I week
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Вох	death certif e attending id for use a	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic p Other (s	pecify)			20	Month	Day Year
o	t the de by the a	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown			, , , _					
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying	cause give	n in Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
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ပ္ထ	aw requ is been 2 should	plet							24a. Was		24b. Were auto	psy findings available
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<u> </u>	ding Pt h. After th funeral	on:	27. Mann of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28d. Describe h	now injury	occurred	
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Division of	ital or A rs efter el Direc led in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y) 				City or Tox	vn, State)		al Route Number,
	To the Hospital or Attending Physicien: within 24 hours eiter death. To the Funerei Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifying Physic (Check only one)	cian: To the best of my known: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred vestigatio	d at the tim	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. o the cause(s)
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}	1		Consitus	Jonney	MI	0	000	23811		5/2	120	06
1	0		30. Name and address of person who con	npleted cause of death (Iten	23a) (Type,	Print)	1	. #	11	Bur		1
J	У		Jonathan 10	man MD	14061	35	/ Mu	in 304	glen	DUN	Ke M	21061
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regištrar's Signa	uure A	nouls	9		•			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year **Physician** April 29, William Edward Miller, Sr. 2:44 p M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 304B Canterbury Road Harford Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 18, 1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2□F Yrs. Director Mary land 218-22-5738 78 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 27 is markad othar than "natural", or Itams 23a or 28a-1 show traumatic avant, the Medical Examinar must be notified at 10d. Inside City Limits Md. Harford Director Bel Air 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or flams 23a any injury or other fraumatic avent, the Medical Expriner must once. 304B Canterbury Road 21014 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years salesman candy distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Miller Mary Ioma Fennington ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Miller, Jr./son 2710 Bauernschmidt Drive, Essex, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 5/2/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Duran a. 1 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician DISEASE CORDNARY ARTER! disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ISCHEMIC CAPDIO MYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (of as a consequence of). The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate -04SLIPIJE MIA Division of Vital 1□ Yes 1 ☐ Yes 2 Z No 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours after death.

In Funeral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely f (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)0051209 May 1,2006 30. Name and address of person who completed cause of death (It / 23a) (Type, Print) Lester Leung, M.D., 520 Upper Chesapeake Dr., Suite 201, Bel Air, Md. 21014 31. Date filed (Month, Day, Year) 32. Registra s Signature State MAY 0 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		1- State of Maryland / Department of Health Certificate of Death			ene) 06	14033
Physici	an	1. Decedent's Name (First, Middle, Last) Anthony J. Micriotti		Date of Death	2006 Yea	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		ly 1, 2	4c. County of De	12:20 рм
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1	er 24 Hrs. 8. D Min. 0C	Date of Birth Month, Day, Y	(ear) 9. E	Birthplace (State or Foreign Country) ennsylvania
yland Now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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with th	Dire	10e. Street and Number 10f. Zip Code 1400 Bonnett Place 21015		100	g. Citizen of What	Country?
death ms 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	origin? (Specify)	Yes or No-		nerican Indian,
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n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) [Secondary (0.13)] [Secondary (0.13)] [Ife. DO NOT use retired)	ost of working	16	6b. Kind of Busines	s/Industry
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Te, Maly ic		19a. Informant's Name/Relationship (Type, Print) Paulette Turkel/daughter 12747 Folly Quart				
s 1 an of Heal ftem 2	- 8	20a. Method of Disposition 20b. Place of Disposition (Name of	Date		ott City oc. Location - City o	
Deathillore, Williams, Pages 1 and 2 Department of Health a Important: If item 27 is eny lojury or other tra			5/5/200	6 S	ykesvill	e, Md.
permit. Depart Import ony Inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facili Schimunek Fune	ral Hom	e of B	el Air,	Inc.
. 3a%		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	1 Road.	Rel A	ir. Md.	21014 Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. ARIM ABRIVAN & BRIVAN & BRIVAN & ABRIVAN & ABRIVA	5 541 6146 67 7 634	Jiratory arrest	ι,	Interval Between Onset and Death
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Examiner	_	Sequentially list conditions, if any, leading to immediate b. SICK SINUS SYNDME Due to (or as a consequence of):				
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an and	Еха	Due to (or as a consequence of):				
tificate be executed g physician and es the burial-transit	edical	d. HTN (HPENTESION)				
h certific	/Me	IF FEMALE: 23h Was deceded program: 23c. If yes, outcome of pregnancy				
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use es the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome or pregnancy or pregnancy of pregnancy at time of death of the pregnancy of the pregnant at time of death of the pregnancy of the pr			23d. Date of de Month	elivery Day Year
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ystcia is cert direct	To B	examiner?	e of Death (Che		e 6 Other (Sp.	A551520
Attending Physician: r death. sctor: After this certification the funeral director.		27. Manne of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?			injury occurred	LIVING
ttendideath.	cati	2 Accident investigation M 1 Yes 2				
al or A after I Direct	Certification	4 Homicide determined determined building, etc. (Specify)	28f. Lo	ity or Town, S	at and Number or F State)	Rural Route Number,
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.	nd place, and du ath occurred at t	e to the caus he time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
To the To the comp	ž	29b. Signature and title of certifier 29c. License number		29d.	Date signed (Mon	th. Day, Year)
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41		29b. Signature and title of certifier The production of the produ	RD SULL	NE 114	-1/L BE	21015
Stat Registra	•	31. Date filed (Month, Day, Year) MAY 0 4 2006 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiera O. C.

			1 - For State Registrar	State of Ma			ificate of L		nentai Hy	/giene Reg. No	. 0 0 0	14034
			1. Decedent's Name (First, Middle	, Last)					2. Date of De Month			3. Time of Death
	Physici /Medio		Katie Bolton	n Mansfield					April	29,	2006 Year	1:30A M
)	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							. County of Death		
			Genesis Elder			_	LaPlata If Under 1 Year	If Under 24 Hrs.			Charles	
	Funeral Director		5. Social Security Number 219-36-7658 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2 □ F	e (In yrs. last birtl 92 Y		Months Days	Hours Min.	8. Date of Bi (Month, Di Nov. 4	ay, Year)	9. Birth Cou	place (State or Foreign intry) 71and
	iand ow		10a. State 10b. County		10c. City, Town	or Loca	ition					10d. Inside City Limits
	Many Figure	tor	Maryland Charl	es	LaP1at	ta						1 ☐ Yes 2 No
	r 28g	Irec	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	intry?
	th wil	alD	l Magnolia Driv	re			20646			Unit	ted Stat	es
9	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "naturaf, or itams 23a or 28a-1 ahow marked other than "naturaf, primaric event, the Medical Exemiter must be invilled a	Funeral Director	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Armed Forces? ed 1 Yes 2 If Yes, Give				spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,	
8	ours LEA	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:			Yes 21 No	Specify:			Specify: Wh:	ite
21215-0036	natu	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. (Deceder	nt's Usual Occupa nd of work done d	ition luring most of work)	ang		ind of Business/Ir	•
2	withir ene. then	d m	Elementary/Secondary (0-12)	College (1-4or 5	i+)		icher				ntgomery blic Sch	•
2	Hygid ther ther	ပ္သ	17. Father's Name (First, Middle,	<u> </u>		Tea	icher	18. Mother's Nam	e (First, Middle	-		0018
Maryland	d is a	To Be	William Henry	Bolton				Katie M				
a Z	Shou nd M	-	19a. Informant's Name/Relationsh		19b.	Mailing	Address (Street a	nd Number or Rur			or Town, State, Zij	Code)
	s 1 and 2 should if Health and Men Itam 27 Ia marke other traumatic		John R. Whitne	y/Grandson				, Annapo				
<u>e</u>	of Hein Itam		20a. Method of Disposition		20b. Place of I	Disposit	ion (Name of tory or other place		Date		ocation - City or Te	
Ē	Page nent c int: If		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i		1	on (Cemeterv	200	6	Beth	nesda, Ma	rvland
Baltimore,	permit. Pages Department of I Important: If It any Injury or of		21. Signatur	iq en see		22. N	Name and Address	s of Facility Rob	ert A.	Pumr	hrev Fu	neral Home/ onsin Avenue
20	20 E 9 9	N 19	raid	lessy		Der	nesua, r	laryranu	20014-	-2201))/ Wisco	onsin Avenue
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do no							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Extr	ap	yrami	dal	Syno	Jac K	me	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	f): /	1		l			
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5	exec in an	Examin	resulting in death) Last	Due to (or as	a consequence of	f):						
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٥	ng ph		IF FEMALE:									
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j.	the d	ysic	1 ☐ Yes 2 ☐ Ño 9 ☐ Unknown	9□ Unknown	tane or death	300	mier (specify)					
ώ T	requires that een signed b hould be deta	by Pr	Part II. Other significant conditio	ns contributing to death bu	at not resulting in t	the unde	erlying cause give	n in Part I.	23e. Did 1	obacco u	use contribute to t	he cause of death?
cords	quire an sig uid b								1 🗆	Yes 2	⊡No 3□ Prot	oably 4 Unknown
ă)	10 to 10	Completed							24a. Was		24b. Were auto	psy findings available mpletion of cause of
Ē	The lav ate has page 2	E							auto perfo	rmed?	death?	
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?		.,			26. Place of Deat				
5	Physician: this certific ral director,	ၟႍ	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	patient	3 DOA Other	r. 4 Nursing Ho	me 5□Resi	dence (6 □Other (Specif	y)
	S je	ë.	27. Manner of Death 1 ☑ Watural 5 ☐ Pending	28a. Date of Injur (Month, Da)	Y Year) 28b. Tir Inj	me of ury	28c. Injury Work	?	28d. Describe	how injur	y occurred	
<u>s</u>	Attanding r death. actor: After by the funer	cat	2 Accident investig	ation of be				es 2 No				
DIVISION	or All	Certification:	4 Homicide determi		iry - At home, farn : (Specify)	n, street	t, factory, office		28f. Location (City or To		d Number or Rura)	al Route Number,
	spital ours neral filled		29a. Certifier	Physician: To the best of	of my knowledge	death =	neumid at the time	u idata and rulana.	and this to the	causade)	and carries as a	totad
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edlcai	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examination and/	or inves	tigation, in my opi	inion, death occurr	ed at the time,	date and	place, and due to	the cause(s)
	To th To th comp	M	29b. Signature and title of certifier	/N.	Jayan	Than	29c. License		7	29d. Dat	te signed (Month,	Day, Year)
	5		30. Name and address of person v	who completed cause of de	eath (Item 23a) (T	ype, Pri	nt) RN.	-573 waldu	7/ n	nd	20/0	2
	- Cto		31. Date filed (Month, Day, Year)		r's Signature	21)	1-01	00 -0-0	U	(-
	Sta Registra		MAY 0 4	2006 Alexander	1 A A	1034						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 750 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Maryland medical Center Baltimore 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) 15 M 2 F Months Days Hours 215-70-684 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No mo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? bourne 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MILLER Ohnnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) melboun e Rd. Idine Milles 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Seurial 2 Cremation 3 Removal from State Conation 5 Other (Specify) Arbutus mem. 21. Signature V uneral Selvice Ucens 70 FredHILTON 23a. Part Entertheursease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pleant failure. List only one cause on each line.

Immediate Cause (Final disease or condition Home balb. md. 21229 Approximate Interval Between Onset and Death nematomo month Subdural disease or condition resulting in death) Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year 4□Pregnant at time of death Month Day 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

10a. State

Examiner

Funeral

Director

or 28a-f ahow

or items 23a

"natural",

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'may Injury or other traumatic avant, Item May ODGE.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

other traumatic avant, the Medical Exacultar must be notified at

Examine Physician/Medical

The law requires that the death certificate be executed attending physicien and for use as the burial-transit ed by the a detached f has been signed by ye 2 should be detact Be Completed by page 5 certificate Physician: After this certification, funeral director, ٩ Medical Certification: To the Hospital or Attending death. within 24 hours after death To the Funerel Director: A completely filled in by the f the

P.O.

Records,

Vital F

o

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
O I Heknows

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cocaine	use	 		

24a. Was an autopsy perform 2 No 1 Yes

1 Tyes

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

3 ☐ Probably 4 ☐ Unknown

25.	was case examined?		to	medica
	examinar?	2 🗌 No		
27.	Manner of	Death		

1 □Natural 2 ☑ Accident

3 Suicide

one)

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 3906

1 Inpatient

28b. Time of NK 1 ☐ Yes 2 No

2 ER/Outpatient 3 DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

26. Place of Death Check only one

from stancing

29a. Certifier (Check only

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home

281. Location (Street and Number or Rural Polite Number, City or Town, State)
4803 Melberne Ave 2 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lothling Mayes

31. Date filed (Month, Day, Year)

WAY 0 4 2006

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** GARRY 2115 PM APRIL NICHOLSON 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. Tw. Town, or Location of Death Examiner Baltimore Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 218-60-6654 1**X** M 2□ F Yrs. Director Usual Residence of Decedent with the Maryland City, Town or Location 10d. Inside City Limits 10b. County 10c 10a. State rthen "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** timore 10e. Street and N 10f. Zip Code 10g. Citizen of What Country? 21133 Koao death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. (A)O NOT ase retire() permit. Pages 1 end 2 should be filled within 7: Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "ns eny injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Maiden Sumame) Father's Name (First, Middle, Last) 0 19a Inf mant's Name/Relationship (Type, Print) 19b. Mailing A Town, State, Zip Code) 20 town 10021133 icholson 20a. Method of Disposition Place of Disposition (Name of Date 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundra Service icensee Red Ustown, MD 21133 23a. Part1. Entertool disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ivy hosis /Medical Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a c Examiner the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete hes 2☑No 1 Yes After this certifice funeral director, p or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3□ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number HOO 5/33 30,2006 ompleted cause of death (ftem 23a) (Type, Print) Old NWIR 5401 31. Date filed (Month Day, Year) 32. Registrar's Signature State Mark

DHMH 17 Rev 1/2001

Registrar

	4/	1. Decedent's Name (First, Middle, Last,	#19a Per FH G855 5	prificate of Death	2. Date of Death	No.	3. Time of Death			
ysici	- 30	Inez Frieda O'Rou	rke		April 28		8:15 p			
Medic camir	1.0	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	h 4	c. County of Dea	ith			
400	100 mm	2525 Pot Spring Ro	ad	Timonium		<u>Baltimor</u>				
neral		5. Social Security Number 6. Se	TM 2187 F	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yea		thplace (State or Fore ountry)			
ctor		212-03-0051 Usual Residence of Decedent	91 Yrs.		Jan. 3, 1	915 PA				
7		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Lim			
fled	tor	MD Baltimor	e Timonium				1 Yes 2X			
To the	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Co	ountry?			
1	a D	2525 Pot Spring	Road	21093		USA				
EL CI	Funeral	11. Marital Status		 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi				
H	by Fu	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 No	1 ☐ Yes 2 🕱 No Specify: Wh	ite	Specify: W	hite			
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ent,	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid					
ii e	ToB	John F. DeShong		Mildre	d Oakman					
E ma		10a Informant's Name/Relationship (T)	ype, Print) 19b. Ma	iling Address (Street and Number or Ru	ural Route Number, Cit	y or Town, State,	Zip Code)			
er tra	١.,	Wilber O'Rourke	- Husband 2525	Pot Spring Road T						
r oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	20b. Place of Dis	position (Name of rematory or other place)	Date 20c.	Location - City or	r Town, State			
ury o		4 ☐ Donation 5 ☐ Other (Specify)	Metro Ci	rematory, Inc. Apr	il 30, 2000	Ealti	more. MD			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Imm 27 is marked other than "natural," or itams 23s or 28s-1 show any njury or other traumatic event, it a Marylan Examinat must be multised at once.		21. Signature of Funeral Service Utens	see (22. Name and Address of Facility Cremation Society	of Maryland	d Inc.				
a a		MIN DO	Marion 1	199 FrederickRoad	Catonsvil'	le MD 2				
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cian	e Vi	Immediate Cause (Final disease or condition	a Dehydr	at'on			days			
dical		resulting in death)	Due to (or as a consequence of):	> 11						
\$.	_	Due to (or as a consequence of):								
Examiner		Sequentially list conditions,	b. Due to (or as a consequence of):	Dence na			Years			
ısıt	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	Strakes			Years			
al-transit	xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):	Strokes			years			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) May 20ď5 2; 11:00A M **Physician** James Clayton Owings /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Reisterstown Rd. 5520 Gilead Rd. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | Oec. 20, 1934 | Maryland 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XiX M 2□ F Yrs. Director 218-32-5686 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir then "naturel", or items 23a or 28a-f ehow The Medical Examiner must be notified at 1 Yes XXNo Completed by Funeral Director Reisterstown Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21136 Gilead Rd. 5520 Mt. 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

XXX Yes 2 No 1957 -13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "nature!, or Iten eny injury or other treumatic event, the Medical Exercities. 1 Never Married XX Married 1 □ Yes 💥 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Schoolbus Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ollie Gamber Clayton Owings P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5520 Mt. Gilead Rd. Reisterstown, MD 21136 Margaret Owings / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Gilead Cemetery 5.5-06 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 21. Signature Fineral & rvice Licens 11605 Reisterstown Rd. Owings Mills, MD21117 THERE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an hes autopsy performed? 1 Yes 2 No 2500 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. unerej Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funerel D Medicai 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of death (Item) 23a) (Type, Print) Kelling Cross & 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For		Maryland / Depa	artment of	Health a		_	14039
-			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	
	Physici	20	Decedent's Name (First, Middle, L.	.ast)				2. Date of De Month	Day Year	3. Time of Death
	/Medic		Martha Frances	Odum				April		9:55 a ^M
	Examin		4a. Facility Name (If not institution, g	ive street and number	nr)	4b. City, Town,	or Location of	of Death	4c. County of Dea	ath
			10129 Hyla Brook			Columbi		O4 Heal I a Builder	Howard	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7 1 □ M 🏋 🖫 F	Age (In yrs. last birthday) Yrs.	If Under 1 Yea Months Day		Min. (Month, Da		rthplace (State or Foreign ountry)
	Director		417-16-4524	Z.W. Z.W.	98 ***			April	27,1908 Te	ennessee
	and *		Usual Residence of Decedent 10a, State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	sho	5	Maryland Howard	1	Columbia					1 ☐ Yes 2 ☑ No
	28a-f	ect	10e. Street and Number		COTUINDIA	10f. Zip Code			10g. Citizen of What C	country?
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	er de Item	'n	11. Marital Status 1 Never Married 2 Married	Armed Force		If Yes, specify Cu	ban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	Black, Wh	
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21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f show the Madigal Examinar must be nutified at	pa	15. Decedent's		16a. Dece	dent's Usual Occ	upation		16b. Kind of Busines	nite s/Industry
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0	filed withi Hygiene. other them	O	17. Father's Name (First, Middle, La	st)	110111011	CHC1	18. Mothe	er's Name (First, Middle		
an	ould be Mental arked o	To Be	Zederic McMille	^			molit	ha Octavia	Into Theore	
Maryland	2 should and Men is marks sumatic	1-	19a. Informant's Name/Relationship		19b. Mail	ng Address (Stre			per, City or Town, State,	Zip Code)
S	and 2 salth ar n 27 is		Linda Odum- daug	hter				d, Columbia		
(a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show amy njury or other traumatic event, the Madical Examinar must be notified at ODEs.		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City of	r Town, State
Baltimore,	ages nt of t: If if		1 Burial 2 Cremation 3		te	matory`or other p		(2/2006	NT1: 11	
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			22a Barti. Sater the disease or or	emplications that cause					mbia, MD 21	.045 Approximate
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Mile.	Physician		Immediate Cause (Final disease or condition resulting in death)	a	511,44					months
	/Medical Examiner		1000mmg in dodiny	Due to (or	as a consequence of):					
·	***		Sequentially list conditions,	b. Due to lor	as a consequence of					
E	sit ad	ine	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due (0 (5)	as a consequence or					
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9 ×	The law requires that the death certifical tens been signed by the attending phystep 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE:	23c. If yes, outcor	ne of pregnancy				23d. Date of d	olhanna
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	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknowr		Other (specify)				
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Sio	Attending r death.	Certification:	2 Accident investiga	t be			Yes 2			
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Ex	caminer: On the basi	est of my knowledge, dea s of examination and/or i					
	the I	Med	one)	and manner	stated.	200 Luce	nse number		29d. Date signed (Mo	oth Day Year)
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	5	-	30. Name and address of person w	no completed cause	of death (Item 23a) (Type	Print)	1 .	07 4 - 5	MM 1 :	0 21204
			HARON CHAN	USS WY	6601 N	i. W	~ 1/5	30 1500	VVVII.C	, -, -,
3		ate	31. Date filed (Month, Day, Year)	229 - 4	istrar's Signature	Andread				
15/20	Regist	rar	MAY 0 4	2006	Was At fill	3492				

Francis Orlando

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2006 24 Francis Orlando /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₹M 2□F Yrs. Director 219-30-1283 71 June 28, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or iteme 23a or 28e-f show traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Bel Air Rd. 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 A Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be if Department of Health and Mental h Important: if Itam 27 is marked otl any injury or other traumatic even QRCs. unk Pages 1 and 2 should be nent of Health and Mental unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mariner Health of Overlea 6116 Bel Air Rd. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☒Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 mm// // 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director; After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transle Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 X FR/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and the of certifier

State Registrar

te 31. Date filed (Month, Day, Year) ar MAY 0 4 2006



who completed cause of death (Item 23a) (Type, Print)

Blud Baltimore MD 21239

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Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death				
/Medic	cal	Catherine Miller 4a. Facility Name (If not institution, give st.			4h City Town or	Location of Death	APRIL	2.8 200 4c. County of De	6				
Examin	ıer	1105 Circle Driv				Location of Death							
Funeral		E. Carriel Canada Musebas C. Cov	7 400	(In yrs. last birthd	Arbutus (ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	Baltimor	irtholace (State or Foreign				
Director		213-20-0443	u 2 F	83 Yrs	Months Days	Hours Min.	July 1	, 1922 Bal	to, MD				
and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d, Inside City Limits				
Manylis f sho	ō	MD Baltimore		Arbutu	I G				1 Tyes 2 No				
1 28a	Director	10e. Street and Number		mbucu	10f. Zip Code			10g. Citizen of What 0	Country?				
th with	a D	1105 Circle Drive			21227			USA					
r dea	Iner	11. Marital Status	2. Was Decedent E Armed Forces? 1 Yes 2 2.0	ver in U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	- 14. Race - Arr Black, Wh					
rs afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ②N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ite				
2 hou		15. Decedent's Educa	ation		ecedent's Usual Occup			16b. Kind of Busines					
hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-		Give kind of work done of fe. DO NOT use retired	during most of work ()	ang						
ygien ygien yer th	Completed	12 th		Gir	1 Friday			Industrial	Corp.				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show sumatic event, Its Medical Examinar must be redified at	Be	17. Father's Name (First, Middle, Last) Carroll Dempsey Mi.	11er					Maiden Sumame) lora Helm					
should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Type		19b. M	lailing Address (Street				Zip Code)				
and 2 ; alth ar n 27 is er treu		Karen Braun Fri	end	11	.03 Circle	Drive Art	outus Ma	ryland 212	227				
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinat must be notified at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Gremation 3 ☐ Rea 4 ☐ Donation 5 ☐ Other (\$pecify)	moval from State	Loudon	isposition (Name of operatory or other place	e s)	Date	20c. Location - City of					
mit. P partme portan / Injur			/	Cemeter	Y T22. Name and Addre	May 4	1, 2006 L Home B	Baltimore Maltimore M	Maryland Maryland				
Depa Impo any i		21. Signature of Fune 18 divice Eleanse Loudon Park Funeral Home Baltimore Maryland 21229											
		23 Part Enter the disease, or Explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart failure. List only one cause on each line.											
Physician		Immediate Cause (Final disease or condition resulting in death)	ISCHEA	MIC CA	RDIOMYOR	PATHY			Onset and Death				
/Medical Examiner				consequence of)	ROTIC CO	P 1747A 124	NIE	EASE					
	ner	if any, leading to immediate	Due to (or as a	consequence of):	:	10007+1-7	0131	. , , , , , ,					
nd nd transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
icate be executed physician and the burial-transit	al Ex	Due to (or as a consequence of):											
physicate s the	edical	d											
nding use a		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of		205			23d. Date of d	23d. Date of delivery				
death	Physician/M	in the past 12 months? 1 Yes 2 No	1□Live birth 2 4□Pregnant at 1 9□Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year				
at the d by the	Phy	9 Unknown		ut and annulting in th		an in Deat I	220 Did to	ahaasa usa cantahuta	to the cause of death?				
signe d be d	1 by	Part II. Dther significant conditions cont AGRIC STENOSIS	-	_					Probably 4 Unknown				
v requ been shous	letec		•				-	an 24h Were	autopsy findings available				
he lav e hes age 2	Completed	SEVERE MITRAL R			(- TIBRILL	autop perfo	prior to death	completion of cause of				
en: T tificat tor, pe	4	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o		es 2 No				
nysicl nis cer I direc	To B	examiner? 1 \(\text{Yes} 2 \text{PNo} \)	spital: 1 🔲 Inpatier	nt 2□ER/Outpa	atient 3 DOA Oth	er: 4 🗀 Nursing H	ome 5 Afesia	dence 6 □Other (Sp	pecify)				
ing PI		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		ıry Wor		28d. Describe h	now injury occurred					
death death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	Irv - At home, farm	M 1	Yes 2 □No	28f Location (5	Street and Number or	Rural Route Number				
al or A	Certification:	4 Homicide determined	building, etc	(Specify)	, street, ractory, omco		City or Tov		,				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C			examination and/o	death occurred at the tir or investigation, in my o								
ro the	Mec	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	nth, Day, Year)				
->-0		Jawrence K	Galla	Ser, M	DO	1786		MAY 02	,2006				
10		30. Name and address of person who cor 7 i6 MM DEN ettal	npleted cause of de	eath (Item 23a) (T)	ype, Print)	UD 21	228						
s Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	1								
Regist		MAY 0 4 2008	Flance	. 1. 1	carrel								

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ent of Health and Meate of Death	Reg. I	4000	14042
5	2. Date of Death May 2, 20	806 Year	3. Time of Death 11:30 PM
City, Town, or Location of Death Brandywine nder 1 Year If Under 24 Hrs. Iths Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan 26,	4c. County of Death Prince Ge 9. Birth 1912 Sou	eorge's place (State or Foreign pth Carolina
dywine City			10d. Inside City Limits 1 ☐ Yes 2 🛣 💑
. Zip Code 20613		Citizen of What Cou	•
ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto P es 2 XX XVo Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Usual Occupation f work done during most of workir IT use retired) A Sing Agent	16b.	Kind of Business/Ir	dustry Government
18. Mother's Name	(First, Middle, Maide eva Mims		50 V C 1 1 1 1 1 C 1 C 1
ress (Street and Number or Rural neltenham Drive	<i>l Route Number, Cit</i> y , Brandywi	y or Town, State, Zij ine, MD 20)613
(Name of Digital or other place) n Cemetery May		Location - City or To	
e and Address of Facility Lee andria Ferry Roa			6633 01d 0735
mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
ic pregnancy (specify)		23d. Date of deliver	ery Day Year
ng cause given in Part I.		o use contribute to to	ne cause of death? pably 4 XIUnknown
	24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of 2 No
26. Place of Death Other: 4 Nursing Hom	ne 5XXResidence	6 ☐Other (Specif	iy)
Work? 1 ☐ Yes 2 ☐ No	8d. Describe how inj		I Court All water
red at the time, date and place, a	City or Town, Sta	ate)	
tion, in my opinion, death occurre	d at the time, date a	nd place, and due to	tated. the cause(s)
29c. License number POOL923		Date signed (Month,	Day, Year) ZNO 6
	0601		
		is the Sparks	

06-02973 Doris

Ме

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s Elaine Prz		State of Mar I-For State Registrar	yland / Departm <i>Certific</i>			nd Mental		Reg. No. 20	106 1404
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of Dea Month		3. Time of Death
dical Exami ⊴	ner	Doris E. Przylepa					May 2, 20	006	1340 hrs
		4a. Facility Name (if not institution, give street and 803 Bentwillow Drive	number)	44	Glen Burn	or Location of De Lie	ath	4c. County o	
Funeral Director		5. Social Security Number 6. Sex 225-24-4437 1 M 2 x	7. Age (In yrs. last bir	thday) Yrs.	If Under 1 Ye		⁄lin.	rth(MM/DD/YYYY) L9, 1922	9. Birthplace (State or Foreign Country) irginia
any	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Locatio	n				10d. Inside City Limits
th the Maryland 23a or 28a-f show notified at once.	ō	Maryland Anne Arundel	Glen B	urnie					1 Yes 2 X No
Mary 28a-	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of Wha	at Country?
th the 23a or notifi	٦	803 Bentwillow Dr.			21061			United	
eath wi items ust be	Funeral		Decedent Ever in U.S. d Forces?	13. Was	Decedent of F s, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. Race - White,	- American Indian, 8lack, , etc.
after d al", or	by F	3 Widowed 4 Divorced If Yes, Give or Dates:	Year	1 1	res 2 🗶 N	lo specify:	_	Specify:	white
hours "natur Exami		15. Decedent's Education (Specify only highest				pation (Give kind fe. DO NOT use		16b. Kind of Bus	iness/Industry
136 hin 72 hours al e. than "natural edical Examin	Completed	Elementary/Secondary (0-12) Colleg	e (1-4 or 5+)	omema	ker		·	own ho	ıme
5-0036 iled within 72 Hygiene. I other than 'the Medical	S	17. Father's Name (First, Middle, Last)	1	011101110		18.Mother's Na	me (First, Middle,	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Oscar Anderson					Chappele		
D 2 should and Mand 7 is ma	1	19a. Informant's Name/Relationship (Type, Print)						mber, City or Town	
ore, MD 2121 s: 1 and 2 should be fi of Health and Mental If item 27 is market ner traumatic event,	ł	Joseph A. Przylepa / h 20a. Method of Disposition			ntwill on (Name of c		Glen Bur		21061 City or Town, State
ages 1 nt of F other		1 X Burial 2 Cremation 3 Remove	al IIOIII Otate	tory or othe		_			
Baltimore, Permit. Pages I and Department of Healt Important: If item injury or other trav	}	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	IMeador	22. Na	me and Addre	ess of Facility	_	Elkridge	
ii ii Beg		Di L Chard		42	1 Crai	n Hwy. S	.E. G1	Home, P. en Burni	e, MD 21061
Physician /Medical		23a. Part I. Enter the disease, or complications th failure. List only one cause on each line.	at caused the death. Do no	ot enter the	mode of dyin	g, such as cardia	c or respiratory ar	rest, shock, or hea	Between Onset and
Examiner			clerotic Cardiovascu	lar Dise	ase			-	Death
		Sequentially list conditions, b							
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d d ansit	Exar	events resulting in death) Last Due to (or and a state of the state o	as a consequence of):						
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68760, certificate be nding physic se as the buri	n/Me	23b. Was decedent pregnant in the	es, outcome of pregnancy ve birth	. Feta	l death 3	B Ectopic pre	inancy	23d Date of o	delivery Day Year
Box 6876 he death certificate the attending phy hed for use as the	sician/M	past 12 months?	egnant at time of death		er (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Suy Foul
Box It the death c by the attentached for us	Phys		nknown ng to death but not resultin	a in the un	derlying cause	e given in Part I	23e Did t	obacco use contrib	oute to the cause of death?
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of Vital Records, ng Physician: The law require wher this certificate has been si meral director, page 2 should t	Completed						24a. Was		Vere autopsy findings available rior to completion of cause of
Recol The law cate has page 2 sl	dwo						perfo		eath?
	യി	25. Was case referred to medical			26. Pla	ce of Death (Che			
Vit.	To B	examiner? 1 Yes 2 No Hospital: 1		utpatient			sing Home 5	Residence 6	
n of ding P h : After e funer		27. Manner of Death 28a. D	ate of Injury 28b. onth, Day, Year)	Time of Inj		jury at Work? Yes 2 No	28d. Describe	how injury occurre	d
Division tal or Attendir as after death al Director: A	ertification	2 Accident Investigation 28e F	Place of Injury - At home, fa	arm, street,			28f. Location (Street and Numbe	r or Rural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death Funeral Director: After this certif tely filled in by the funeral director,	Certi	4 Homicide determined (Spec	eify)			-	or Town, S	State)	
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier 1 Certifying Physician: To the one) 2 Medical Examiner:On the ba	sis of examination and/or i						
- > - 3	ž	29b. Signature and title of certifier				nse number			ed (Month, Day, Year)
		my w, mis		May 3, 2006)				
5		30. Name and address of person who completed Ling Li, MD Assistant Medical E		n Street	, Baltimore	e, MD 21201			
St Regist	ate	31. Date filed (Month, Day, Year) 32	. Rodistrar's Signature	A.	M. a				
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 1 la Olsala For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2006 Year 3, **Physician** May 5:30 РМ Fenton S. Robb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 719 Maiden Choice Lane, BR615 Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAR 31, 1905 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF 101 509-46-1910 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28e-f show Examinational be notified at 1 Tyes 2 No Catonsville Baltimore Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 719 Maiden Choice Lane, BR615 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Mackal Example. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward Howard Smith Anna Maria Condit ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9923 Middle Mill Drive, Owings Mills, MD 21117 Nancy R. King/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) <u>5/4/06</u> Baltimore, MD Metro Crematory, Inc. 21. Signature of Funeral Service ticensee

Survey J. Gregorchik

Edward A. Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death -cox Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No has certificate 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 DOA 2 this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No М Director; filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifie 4 200L (MD who completed cause of death (Item 23a) (Type, Print) 30 Name and address of persen D (ghorsville lane Maide hoio 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eddie E Roberts Year APRIL 2330PM 29 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital St. Agnes BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 5 9 8. Date of Birth (Month, Day, Year) **Funeral** 1**∭**M 2□ F 64 Director 8 - 20 - 41MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow r than "natural", or items 23a or 28e-f ehov the Mudical Examiner must be notified at MD Baltimore X□Yes 2□No Director 10e. Street and Number 2904 Winchester St. 10f. Zip Code 10g. Citizen of What Country? 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72. Dopertment of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumatic event, the Madic 2006. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Man Ligor Distritor 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mable Cheeks un 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Winchester St. Baltimore, MD 21216 19a. Informant's Name/Belationship (Type, Print) Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Cem 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-4-06 Dundalk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wesley Chavis Jr. 2007 Eastern Ave. Jonell L Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia ~ 15days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner that the death certificate be executed Due to (or as a consequence of): 68760, attending physicien a for use as the burial-Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed2 page 1 Yes 2 No Vital funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Unpatient examiner 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA ð this 28a. Date of Injury (Month, Day Year) 27. Mannef of Death After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18612 M.D. Muhammas APRIL 29,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Outon Avenue, Baltimore MD, 21229 TALHA. MUHAMMAD MD 32. Degistrar's Signature 31. Date filed (Month, Day, Year) MAY 0 4 2006 Goode) Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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ROBERTS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 18PN 3000 1 Car RICHARDSON Α. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burne for Modical Center Unne Hrundel Baltimere Washing If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days 1 □ M 2 1 F Months 56 214-54-5714 July 27,1949 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Itema 23a or 28a-f ehow empt hjury or other traumatic event, the Maulical Examiner must be notified at once. 10a. State 10b. County 1 Yes 2 No Maryland Anne Arundel Pasadena Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 808 222nd Street 21122 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status しんけん(いい) といい とい Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗹 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Flint Marv Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 19a. Informant's Name/Relationship (Type, Print) 221 Old Riverside Road, Brooklyn Park, Maryland Evelyn M. Kinnard (Daughter) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville VA Cem. 05-04-06 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Euneral Service Licen ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Heidosis tours Metabolic /Medical Due to (or as a consequence of) Examiner 1 cute Keno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit elonephr resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical ate hes been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3:☐ Probably 4 ØUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours efter deeth. To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Tes 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 (Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Maria Gaviria WO 32. Registrar's Signature 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0032744

301 Hospital DR Glen Burnie Md 21061

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April 29, 2006 **Physician** 1:00 AM Beverly Elaine Robertson /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forest Glenn Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan 30, 1949 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) 1□M 2√X Hours Min Months Days 57 184 38 7120 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is markad other than "natural", or Itams 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits Washington DC 1. Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3636 16th N.W. Apt B 1042 20010 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Never Married 2 Married 1 ☐ Yes 2 TVNo Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 🎌 Specify: 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If ilam 27 is marked other than any injury or other traumating and injury or other traumating and injury or other traumating Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Budget Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winchester Robertson Daisy Lee Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Ford (Sister) 5517 Thompson Road, Charlotte, NC 28216 20b. Place of Disposition (Name of cemetery, crematory or other place) May 4, 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licenses Silver moize4 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Endountried Cancer. Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to [or as a considuence of] burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Who
9 Unknown Day Year Month 4 □ Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Mnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 2 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, D0054566 4/30/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitera Bhogavilli East Joppa Road Seit 230, TOWSON, MD 21286 1220 A 31. Date filed (Month, Day, Year) Registrar's Signature MAY 0 4 2006

DHMH 17 Rev 1/2001

Registrar

		Registrar 1. Decedent's Name (First, Middle, L					2. Date of Dear Month	eg. No. th // Day Year	3. Time of Death	
Physicia /Medica		NORMAN	RIDGEWI	⁴ Y			4	18 06	8.05A	
Examine		4a. Facility Name (If not institution, g	ive street and number)	40 41		r Location of Deat	h	4c. County of Dea	(1)	
		Howard County	+ General hosp	billia		imbid		Howas		
Funeral		Social Security Number 6.	Sex 7. Age (In yrs.	. last birthday) 11	Onths Days	If Under 24 Hrs. Hours Min.	(Month, Day		rthplace (State or Forei Jountry)	
Director		579-38-9248 Usual Residence of Decedent	73	115.			May 25,	1932 Mar	yland	
A 11		10a. State 10b. County	10c. C	ity, Town or Locati	ion				10d. Inside City Limi	
4 B	ō	MD Anne A	rundel J	essup					1 □ Yes 2 <u>√</u> 21	
28a	Funeral Director	10e. Street and Number	runder J		10f. Zip Code		1	Og. Citizen of What C	Country?	
38 0		P.O. Box 700 Pa	tuxent Institu	te	20794			USA		
E E	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was		dispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - Arr		
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>	Be	17. Father's Name (First, Middle, Las					me (First, Middle, i	walden Sumame)		
1 2 2	2	William Bernard			(0)	Mary Ann		A. L. T. C. A. A.	7.041	
a un	- 79	19a. Informant's Name/Relationship Patuxent Instit	* **					; City or Town, State,		
per t				Place of Disposition		Patuxent		te Jessup,		
or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cremato	ory or other pla	ce)	Date	20c. Location - City o	i Town, State	
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permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiens. Depertment of Health and Mental Hygiens important: If them 27 is marked other then "natural", or fleme 23s or 28s-1 show eny injury or other traumatic event, the Maritcal Examit or must be notified at once.		21. Signature of Funeral Service Lio	Wade Pirecto		ame and Addre		4 655 W	Baltimore	Ctwoot	
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hysician /Medical Examiner		23a. Part1. Buter the disease, or co shock, or heart failure. List on	ly one cause on each line.		he mode of dyli	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death	
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		(Check only 2 Medical Expone) 29b. Signature and title of certifier	no completed cause of death (lite	em 23a) (Type, Prin	29c. Licens DO	06034-	mbra	4/18/ MD 21	106 107 4 4	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #20b Per FH C855 5/04/66 rtifficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROCHBERG Day APPL **Physician** 3:20 A.M. 2006 /Medical City, Town, or Logation of Death not institution, give street and number) 4c. County of Death Examiner 3 BALTIMORE Date of Birth 10/23/1917 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√□ F -10-6042 88 MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "naturel", or iteme 23a or 28e-f ehow adical Examiner must be notified at BALTIMORE OWINGS MILLS 1 ☐ Yes 2 X☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 4730 ATRIUM COURT APT. #202 21117 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene, and if Item 27 ie marked other then "naturel", or ite ury or other traumatic event, the Medical Enamiaury or other traumatic event, the Medical Enamiaury 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Battimore, Maryland 21215-0036 by 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **SALESPERSON** RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KLEIMAN DOROTHY ROMBRO DAVID ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6681 LUSTER DRIVE - HIGHLAND, MD 20777 DIANNE R. SAGNER / DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 05 20a. Method of Disposition ARLINGTON CHIZUK AMUNO CONG. Burial 2 ☐ Cremation 3 ☐ Removal Irom State BALTIMORE, MD -02/03/2006 permit. Page Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 otre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** coutur-/Medical Due to (or at a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a Was an 24b. Were autopsy lindings available prior to completion of cause of death? paga 2 s cartificate has 1 Yes Hospital or Attending Physicien: 25. Was case relerred to medical examiner? funeral director, Be 26. Place of Death (Check only of examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) N Inpatient P 2 ER/Outpatient 3IT DOA this 28a. Date of Injury (Month, Day 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Natural Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Funeral Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiel Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Wen Blum. vos. Dur 210/01

DHMH 17 Rev 1/2001

State

Registrar

MEKM

31 Date filed (Month Day Year)

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2. Registrar's Signature

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)	/Medio Examir		4a. Facility Name (If not institution	n, give street and number	ər)	-	4b. City,	Town, or	Location o			4c.	County of D	eath		
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	Funeral		5. Social Security Number 219-16-5833	6. Sex 7. /	Age (In yrs.	last birthday) Yrs.	II Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ay, Year)	927	Birthplac Country,	(State or F	oreign
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	ryland how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d.	. Inside City t	4
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Maryland 21215-0036	C1 00 = 2		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	-0			al Route Numb	1	r Town, Stat	e, Zip Co	ode)	(
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Do	Peges nent of I int: if it		1 Burial 2 Cremation		te a	cemetery, crer	natory or o	ther place	9)	5/2	100	P	14:00	0.00	H.	_
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	Physician		Immediate Cause (Final disease or condition	_ pneu	lman	101								O	nset and Dea	.tn j
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	juence of):										
		-	Sequentially list conditions,	b. Our l	as a conseq	uence of):			<u> </u>							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<		,										
ó	te be executed ysicien and e burial-transit		that initiated events resulting in death) Last	Due to (or a	as a conseq	uence ol):						-				
3760,		icai		d												
89 X	ertifica ling pl	Med	IF FEMALE:	20. 16				***		-						
80	ath catternations	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 Live birth 4 Pregnant	2 🗆 Feta	I death 3	Ectopic pro						23d. Date of Month	delivery Da	ıy Yea	r
o.	the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			J Other (Sp	ecily/								
<u>ر</u> ي ت	s that ned b e deta	Completed by Physician/Med	Part II. Other significant condition			ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco ι	ise contribute	e to the o	cause of deat	h?
ğ	en sig	ed b	ar	nal fibrillat	non					_	1 🗆	Yes 2	□ No 3×	Probabl	ly 4 ∐Unk	nown
မှ	hes be pe 2 sho	pie	CH	F							24a. Was	DSV	prior	autopsy to compl	findings ava	labte e of
Division of Vital Records, P.O. Box	: The cete h	Con									1 ☐ Yes	2 No	death 1 🗆 Y		No	
<u> </u>	sicien: Th certificete rector, pag	Be	25. Was case relerred to medical examiner?	Here well and		155/0		Othe			(Check only o					
ō	Phys or this oral di	5.T	1 ☐ Yes 2/2 No 27. Mangrer of Death	28a. Date of Ir	njury	ER/Outpatien 28b. Time of		8c. Injury Work	4 190		me 5 Resi 28d. Describe			pecity)		
<u>o</u>	nding ath. r: Afte e fun	Certification:	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	9	Day Year)	Injury	м		:? ∕es 2 🗆 !	No						
<u> ≥</u>	r Atte er de: recto by th	tific	3 Suicide 6 Could determ	ined 289. Place of	Injury - At he		eet, factory	, office	-		28f. Location (Street an wn, State	d Number or	Rural R	oute Number	
	utai o urs eft rei Di	Cer														
	To the Hospital or Attending Physicien: The lew requires that the death certifica within 24 hours effector: After this certificate hes been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred vestigation,	at the tim , in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	date and	and manner place, and o	as state due to the	ed. e cause(s)	
	o the	Me	29b. Signature and title of certifie		310100.		290	. License	number			29d. Dat	te signed (M	onth, Daj	y. Year)	
)	8		Fluse 1	luhi-	M	9		DAA	10169	0		ž.	4 28	20	06	
F	, ,		30. Name and address of person	who completed cause o	of death (Item	n 23a) (Type,	Print)	- 0 L			112/					
-			EUNSE MILITELE	UN TSO MI	CIMIZIN		eistei	1219V	NN	100	1136					
	Sta Registr		31. Date liled (Month, Day, Year) MAY 0 4	2006 32 Regis	strar's Signa	d Spot	ul i									
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DHMH 17 Rev 1/2001

		State of Maryland /				•	•	
		1 - State Registrar		tificate of L			No. 0 0 6	14051
		Decedent's Name (First, Middle, Last)	-			2. Date of Death Month	Day Year	3. Time of Death
Physic /Med		JUSEPH SPECTA.				April 27	, 2006	12:30 A M
Exam	iner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Death	•
Funera		Charlotte Hall Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday)	Charlot If Under 1 Year	If Under 24 H		St. Mary	I'S place (State or Foreign ntry)
Directo		539 14 7296 XX 2 F 89	Yrs.	Months Days	Hours Mi	in. (Month, Day, Y	ear) Coul.	ssouri
and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Lo	cation				IOd. Inside City Limits
Maryl -1 eho	Ď	Maryland St.Mary's		rlotte Ha	a11			1 □ Yes 🏋 No
h the	Director	10e. Street and Number		10f. Zip Code		100	. Citizen of What Cou	ntry?
ath wil	raid	29449 Charlotte Hall Road	.,	20622			United St	ates
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-1 ehow ite Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces? AMYes 2 No 1941	13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
O36	by	XX Widowed 4 Divorced Year or Dates: 1941	1	Yes XX No	Specify:		Specify: Wi	ite
5-0 72 ho	Completed		(Give	lent's Usual Occupa kind of work done di	uring most of w	vorking 16	b. Kind of Business/In	dustry
within then	jdm	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired) :visor		Ţ	J.S. Postal	Service
d 2 Hygie other	Be Co	17. Father's Name (First, Middle, Last)	uper			lame (First, Middle, Ma	iden Sumame)	Bervice
aryfan should be ind Mental i marked o	PB PB	Quinto Spelta			Maria	a Soribante	•	
	1.					Rural Route Number, C		
e, N 1 and 1 and Health 6m 27						s Court, Up	c. Location - City or To	-
TOT Pages ent of nt: If It				sition (Name of natory or other place coln Ceme			Brentwood,	
Battimore, Misperial Pages 1 and 2 Department of Health a Important: If them 27 is any Injury or other tra		21. Signature of Funeral Service Licensee			,-	ee Funeral		
<u>ක</u> දිරීළිදි සි		Muenta D. Sibbs moiz84	landon			ry Road,Cli		20735
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dying	, such as card	iac or respiratory arresi	1	Approximate Interval Between Onset and Death
Physiciar /Medica	_			THEE	12/49	MA.		
Examine	_	Due to (or as a consequence	of):					
7 0 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	of):					
60, Cbe executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events c	of):					
	cal E	Due to tot as a consequence	01).					
Box 687 leath certificate attending phys for use as the		d.						
I RECORDS, P.O. BOX 68 The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	h 3□	Ectopic pregnancy			23d. Date of delive	
of the deal by the at tached for	/sici	1 Yes 2 No 9 Unknown	5 🗌	Other (specify)			Month	Day Year
IS, P.	Ph	Part II. Other significant conditions contributing to death but not resulting it	in the un	derlying cause giver	n in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
rds quires n sign uld be	d b	ATHEROSCIEROTIC CARDIOVAS		-		1 ☐ Yes	2 No 3 Prob	ably 4 Dunknown
Records,	Completed	HUPOTHUROIDISM.				24a. Was an	24b. Were auto	psy findings available mpletion of cause of
	Com					autopsy performe	d? death? No 1 ☐ Yes	
VITAL I	Be	25. Was case referred to medical examiner?				eath Check only one)		
Phys rthis ral dir	5	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Ot 27. Manney-of Death 28a. Date of Injury 28b.	utpatient Time of		Nursing	Home 5 Residence		y)
DIVISION OF I or Attending Phy effer death. Director: After this IIn by the funeral d	atton		Injury	Work'	es 2⊠No	250. 5556.155 1101	injury obcarrou	
DIVISIO Il or Attendi efter death. I Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura	I Route Number,
DIVISION OF VITA Hospital or Attending Physician: 94 hours after death. Funaral Director: After this certific fely filled in by the funeral director,								
Di To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledgy (Check only one) 2 ☐ Medicel Examiner: On the basis of examination are and manner stated.	e, death nd/or inv	occurred at the time estigation, in my opi	e, date and pla inion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
To the by within 2.	Me	29b. Signature and title of certifier		29c. License	number	29d	Date signed (Month,	Day, Year)
		Visplans An. D		Doc	567	52 0	4/27/2:	006
IN		30. Name and address of person who completed cause of death (Item 23a)						MD 20622
10		NAZHIN ESPHAYU, (Y.D. Z. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	14	49 CH	ARLUT	TE HALLI	ZUAD, CHAR	LOTTE HALL,
Si Regis	tate trar	h de	1	, .				
DHMH 17 Rev 1/	2001	MAY 0 4 2006 Rights &	L					
			DRÍGI	NAL				

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No.) [4007
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath		3. Time of Death
	Physici		GORDY L SAMPLE	MAY		Year	12:55 PM
	/Medic Examin		4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Li	ocation of Death			
	Examin	٠.	HAMILTON GENESIS CENTER BALTIM	ORE		N/+	+
	Funeral	ę	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, De)	h v. Year)	9. Birthpla	ce (State or Foreign
	Director		228.24.459 15 78 Yrs. Months Days Hours Min.	04.1		- Courni	" VA
	P .		Usuel Residence of Decedent 10a. State 10b. County , 10c. City, Town or Location			10	d. Inside City Limits
	anyla ahov	_	MD N/A Baltimore			10	1 XYes 2 □ No
	Ma M	5			40. 03: ()46		
	A Por	눔	5207 Frankford Avenue Apt 21206		10g. Citizen of Wi		y r
	23.	Funeral Director		posity Voc or No		- America	n Indian
	ar de	Š	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black	, White, et	
36	i', or	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 1 Yas 2 No 1 Yas 2 No Specify: Year or Dates:		Specify:	Blo	ack
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglane. d other than "natural", or items 23s or 28s-f show event, the Medical Exeminer must be notified at	8	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bus	iness/Indu	istry
75	nin 7	를	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ting	 1		
7	d with piana. r thar	E	12-tharade N/A Fechnician		Elect	non	103
g	e filad al Hygi other vent,	e e	17. Father's Name (First, Middle, Last) 18. Mother's Nam)	
<u>a</u>	Menta Menta rked rice	To Be Completed	Sovern Sample Kosa I	MAe	selle		
Maryland	2 should and Mer is marks		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	_			
	and aalth n 27 i		Diane M. Ricks/Daughter 2020 Frame Road	Balto	. MD 2		
Baltimore,	- T 2 5		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Method of Disposition (Name of cemetery, cremetory or other plece)	Date	20c. Location - C	-	
Ĕ	Pagas mant of A ant: if ite ury or o		4 □ Donation 5 □ Other (Specify) Garrison Torest	05/09/06	DWING	MIL	B,MD
ä	parmit. Departmimports Imports any inju		21. Signature Funeral Service Licensee Sico 22. Nam and Address of Facility Corene Facility Corene Facility Core Facility Corene Facility Corene	Ineval	SENTRES		
Ш	20 5 5 2		Mus W. Suc Agus York Road I	3a Ltimor	e MD 2	1212	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.				Approximate nterval Between
	Physician					1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition RESPIRATORY FAILURE			1	
H	Examiner		Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE PILMON				
/	sit ad	edical Examiner	D. CHRONIC OBSTRUCTIVE PULMON	ARY D	ISTAJO	-	
	The law requires that the death cartificate be assected the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	хал	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
68760,	ba a) ician buria	జ	cause. Enter Underlying Ceuse (Disease or injury c			i	
387	phys tha	욹	that initiated events resulting in death) Last Due to (or as a consequence of):			1	
×	ding sa as	Appeals .	d				
P.O. Box	attan for u	clar					
o	tha d	X	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	/		the cause of death?
صِّ	v raquiras that tha daath car bean signed by tha attandir should be datached for usa	4	MULTIPLE LUNG NODULES	161	res 2 No	3 Probl	ibiy 4 Officiowii
Sp.	uiras 1 sign 1d be	Q P		24a. Was	an autopsy	24b. Wer	e eutopsy findings
ဂ္ဂ	bear bear shou	ete	DEMENTIA	perfor	rmed?	com	lable prior to pletion of cause eath?
Ä.	has ya 2	Completed by Physician/N	NEUROSYPHILLS	40.	es 21 No		Yes 2□ No
co.	n: Tr ficate or, pa	ပ္	25. Was case referred to medical 26. Place of Deel			- 1	162 2 10
₹	Attending Physician: r death. ector: Aftar this cartifice by the funeral director;	o Be	examiner?		ience 6 □Othe	r (Specify)	
ō	Phy r this	5	27. Menney of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurre		
5	oding th. Afte a funi	흝	1 ☑Netural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division of Vital Records,	Atter r dea ector by th	Hice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number	r or Ruret	Route Number,
	s afta	Certification:	a Chomicide building, etc. (Specify)	Chy of You	m, Oldio)		
	oapit hour inera		29a. Certifier (Check only Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occur.)	end due to the d	ause(s) and man	ner as ste	ted.
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this cartificate has complately filled in by the funeral director, page 2	ledicai	one) and manner stated.				
	To T	Σ	29b. Signature and title of certifier ACTONDING 29c. License number		29d. Date signed		ey, Yeer)
}	£		PHYSICIAN DOUGOD	37 1	1AY /	20	06
	3		30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) HAMILTON GO 40 HATTOND ROAD, BAT- 31. Date filed (Monte Pay, Year) 4 2006 32 Segistrar's Signature	130 NS	R.	, ,	2 10
			31. Date filed (Month Rey, Year) 4 2006 32 Segistrar's Signature	TIM ORG	s, MU	0 0/	014

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 11:12 PM Margaret Elizabeth Schroen 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Anne Arundel Linthicum 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖫 F Director 219-12-6123 81 21, Maryland Dec. 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₩ No Directo Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 7410 Race Rd 21076 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or Itame 23 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by Specify. 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Joseph Franklin Marks Edith May Wheat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Deportment of Health ar Important: if item 27 is any njury or other trau once. Sharon Dorman-daughter 7410 Race Rd, Hanover, MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem.Park 5/3/06 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ADRTIC STENOSIS YEARS /Medical Due to (or as a consequence of): Examiner ANASARCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of -transit The faw requires that the death certificate be executed CORONARY ARTERY

Due to (or as a consequence of): physician a s the burial-P.O. Box 68760, Completed by Physician/Medical DIABETES MELLI IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No NIA 23d. Date of delivery 3 □Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been sig 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No rector, page 2 s Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 28c. fnjury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending frigury death NIA 1 ☐ Yes 2 No investigation 2 Accident after death Director: within 24 hours after de To the Funaral Directo completely filled in by th 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DZZ83Z took lan, Mes 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) , Soon JA Kim, 0 5808 ELKRINGE, MD 21075 MAIN STREET 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 MAY 0 4

			For Stata	State of	Maryland	_	artment of				Con	JUU	1.051
			Registrar 1. Decedent's Name (First, Middle, La	ist)			imouto o	Doam		2. Date of Dea	Rag. No.		3. Time of Death
	Physici		George Henry Snyd							Month	Day	-	2/2 1 M
	/Medio		4a. Facility Name (If not institution, giv		ber)		4b. City. Town.	or Location	of Death	May !	40	County of Death	17-1
	Examir	ier	Baltimore Washing			ter	Con	1/5		2	1	4	Le And
	Funeral				. Age (In yrs. la:		If Under 1 Year	r If Under	24 Hrs.	8. Date of Birtl	h	9. Birth	place (State or Foreign
	Director		219-28-7062	1⊠M 2□F	73	Yrs.	Months Day	Hours	Min.	(Month, Day Nov. 1:		932 MD	intry)
			Usual Residence of Decedent		7.5					NOV. I.	J , I	JJZ III	
	ylang		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mar Milia	tor	MD Anne Aru	ınde1	Mil1	ersvi	.11e						1 ☐ Yes 2 🙀 No
	h the	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	intry?
	h wit	a D	229 Severn Road				21	108				U.S.A.	
	deat	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S.		Was Decedent of	Hispanic Or	rigin? (Spec	ify Yes or No-	.]	14. Race - Amer	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Idea of ther than "neturel", or items 23e or 28e-f show event, the Medical Eracriner must be routified at	þ	1 Never Married	1 Tyes 2 If Yes, Give Year or Dat	2 ₩ No		fYes, specify Cu 1 □ Yes 2 X N			ican, etc.)		Black, White Specify: wh:	
2-0	72 hc	Completed	15. Decedent's E (Specify only highest gra				ient's Usual Occ		et of workin		16b. Kii	nd of Business/I	ndustry
21	within 7 ene. than "r	ple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of work don OO NOT use retii	ed)	St Of WORKING	9	Dep	t. of L	icensing &
2	giene grene er than	NO.		2		Safet	y Super:	intend	ent		Reg	ulation	
멀	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle,	Maiden	Sumame)	
<u> a</u>	should be nd Menta marked imatic ev	Tof	George Henry Snyd	er, Sr.				Elea	nora	Linthio	cum		
an	0 6 8 9		19a. Informant's Name/Relationship (Туре, Print)		19b. Mailir	g Address (Stree	et and Numb	er or Rural	Route Numbe	r, City o	r Town, State, Zi	p Code)
	1 and 2 Health tem 27 I		Mrs. Gloria M. Sn	yder / w	ife	229	Severn I	Road;	Mille	rsville	e, M	D 21108	
<u>S</u>			20a. Method of Disposition	3D	con	ce of Dispo	sition (Name of natory or other p	ace)	Da	te	20c. Lo	cation - City or T	own, State
Ĕ	Pages nent of I ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specil			n Have	en Mem.	Park N	May 6	2006	G1e	en Burni	e, MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	nsee	/	22	. Name and Add	ress of Facili	ySing	leton I	Tune:	ral Home	PA
8	88188		Mark.	Vancura	No.	3571	Second	Ave S	W; G1	en Burr	nie,	MD 2106	51
	y.		23a. Part1. Exter the disease, or com- shock, or heart failure. List only	plications that car	used the death.	Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	the.	4>	200	50						Onset and Death
	/Medical		resulting in death)	a. Due to (o	r as a conseque	nce of):							Jan J
	Examiner			Az	15/11.	Bor	mi De	2200	20.				DAZI
	* *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a conseque	nce of):			1		-		7
	cuted nd ransi	Examiner	that initiated events	c									
ó	e exe ian a irial-l		resulting in death) Last	Due to (o	r as a conseque	nce of):							
8760,	cate be executed physician and the burial-transit	dical		d									
9	ng pł	Ned	IE EEMALE.							-			
Вох	death certifica e attending pt d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnand th 2 Fetal d		Ectopic pregnan	cv			, 2	23d. Date of deliv	
	A M A	slci	in the past 12 months? 1 Yes 2 No		nt at time of dea		Other (specify)					Month	Day Year
P.0	requires that the een signed by th hould be detache	h	9 🗆 Unknown								1		
	es tha igned be de	by F	Part II. Other significant conditions of	contributing to dea	th but not resulti	ing in the ur	nderlying cause g	ven in Part I	l.	23e. Did to	bacco u	se contribute to	the cause of death?
pro	w requir been si should I		JA beter.	Myre	year	ero~	_			1 🗆 Y	es 2[□No 3□Pro	bably 4 Unknown
Records,	aw is b	Completed		,						24a. Was a		24b. Were aut	opsy findings available
Ä	0 - 0	E								autops perfor	med?	death?	2 No
Vital		Be C	25. Was case referred to medical					26. Place	e of Death	Check only on		10,100	2,2110
>	Physicien: this certific ral director,	ToB	examiner? 1 🗌 Yes 2 🗖 No	Hospital:	patient 2 EF	R/Outpatien	3 DOA C	thor				Other (Speci	fv)
l of			27. Manner of Death	28a. Date of	Injury 2: Day Year)	8b. Time of Injury	28c. inj			d. Describe h			
<u>ö</u>	Attending r death. sctor: After by the fune	atlo	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigation		Day (Gai)	піцату		Yes 2	No				
Division	Atte	ertification:	3 Suicide 6 Could not b	280. Place 0	f Injury - At hom g, etc. (Specify)	e, farm, str	et, factory, office		28	If. Location (S. City or Town			al Route Number,
	s afte	Cerl	1 1 0 1 1 0 1 0 0 0 0 0 0 0 0 0 0 0 0	Dunaning	, etc. (opecity)					Only of Town	n, olale)		
29a. Certifier Check only 29a. Certifier Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time,							d due to the c d at the time, d	ause(s) late and	and manner as s place, and due t	stated. o the cause(s)			
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	. 314134.		29c. Licer	ise number		2	9d. Date	e signed (Month,	Day, Year)
			10 10	17	,	1-1	λ	101	_		/		3 3 -
•	, of		/ oras le	Konre	es-b	(4)	12-	46	130	(1	40	J/ Dus	2006
	10		30. Name and address of person who	completed cause	or death (Item 2	(Type,	rint)	win.	12.0	Ano	red		
	V C		31. Date filed (Month, Day, Year)	32 Ray	nistrar's Signatur	c re	ok north	ne p	-163	200	6/		
	Sta Registr				1	ly A	reelis						
211			MAY 0 4	2006	ALUS &	r M	AND SHOWS						

DHMH 17 Rev 1/2001

George Suyder

			1 - For State of Man	yland / Depa		Health and M	Mental Hygier	ne2006	14055
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	Oscar Leroy Schafer, Sr	•	# 0> T		05 0	2 200	
	Examir	ner	4a. Eacility Name (If not institution, give street and number)	ita 1	Ab. City Town, o	or Location of Death		4c. County of Deat Battin	n
	Funeral			In yrs. last birthday)	If Under 1 Year		8. Date of Birth	9. Birt	hplace (State or Foreign
	Director			4 Yrs.	Months Days	Hours Min.	Nov. 1, 1	931 Mar	yland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
1	with the Maryland a or 28s-1 show be notified at	tor	Maryland Baltimore	Ki	ingsville				1 □ Yes 2 No
\prec	or 28	Direc	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	,
4	s 23a	Funeral Director	7519 New Cut Road		<u> </u>	21087	7 7 7	U.S.A	
200	after des	Fun	11. Marital Status 12. Was Decedent Eve Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ Ŋo) 1		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	e, etc.
303	ours a	þ	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 ☑ Yes. Give Year or Dates O	rean rhlict	1□Yes 2X No	Specity:		Specify: W	ute
15-0	within 72 hours after death with the Maryland ene. then "neturel" or Items 23e or 28e-1 ehow the Madical Exembler must be maillisd at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	dent's Usual Occup	pation during most of work ed)	ing 16b.	. Kind of Business/	Industry
212	d withingiene.	omp	Elementary/Secondary (0·12) College (1-4or 5+)		Represe			Paint Co	•
A B	be filed stal Hyg d otherwent,	Bec	17. Father's Name (First, Middle, Last)		•	18. Mother's Name	e (First, Middle, Maid	en Sumame)	
yla	should be and Mental le marked o	٦ L	Harry Schafer			Margari			
Man	カモトキ		19a. Informant's Name/Relationship (Type, Print) Mrs. Alfie Schafer (wife)				al Route Number, Cit 198Ville,		
re.	s 1 and of Health Item 27 other tr		20a. Method of Disposition	20b. Place of Dispo		-	-	Location - City or	
imo	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment	-		1	2006 Ba	ltimore.	Maruland
Baltimore	permit. Pages Department of Important: If II any Injury or o		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ess of Facility Sch	rimunek Fu	neral Hoi	nes
	707 4 0		23a. Part1. Enter the disease, or complications that caused the				Baltimore,	MD 212.	
	Dhysisian		shock, or heart failure. List only one cause on each line.	y death. Do not ent	ter the mode or dyr	ng, such as cardiac t	or respiratory arrest.		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	gnsequence of):					
	Examiner		Sequentially list conditions. b. Lung	Cancer					
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):					
ć	te be executed ysiclan and he burial-transit	Exan	that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):					
760,	ysicla	cai	d						
Box 68	ath certifica itending ph or use as th	Med	IF FEMALE:						
Bo	attend I for us	clan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of part of the past 12 months? 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deli Month	very Day Year
P.O.	that the death ed by the atter detached for	hysi	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown						
, a	Attending Physician: The law requires that the death certifica ector, alth. scrot.akin. scrot.	Completed by Physician/Med	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause giv	ven in Part I.		o use contribute to	the cause of death?
ord	requir	eted	a hair is the state of the stat				1 V Yes	2 No 3 Pr	obably 4 Unknown
Bec	The law cate hes b	mple	atrial fibrillation				24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
tal	iclan: Th certificate ector, pag		25. Was case referred to medical			26 Place of Death	1 ☐ Yes 2 ☑ N	No 1 ☐ Yes	200 No
Ž.	Physiclan: this certific al director.	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ✓ Inpatient	2 ER/Outpatien	nt 3 DOA Oth	200	me 5 Residence	6 □Other (Spec	eifv)
0	ding Ph h. After th funeral		27. Manufer of Death 1 Natural 5 Pending (Month, Day Ye	28b. Time of Injury	Wor	rk?	28d. Describe how in	jury occurred	
Division of Vital Records,	death.	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	- At home form etc		Yes 2 □No	28f. Location (Street	and Number of D	m/ Courte March
Div	al or A after I Direct d in by	Certification:	4 Homicide determined 288. Place of tripling building, etc. (\$	Specify)	eet, factory, office		City or Town, Sta	ile)	rai Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner:	ny knowledge, death	n occurred at the tir	me, date and place,	and due to the cause	(s) and manner as	stated.
	the thin 24 the F	Medi	one) and manner stated						
	5. <u>₹</u> 5 <u>8</u>		White Town)	29c. Licens	UVVVV De ununger	29d. E	Date signed (Month	Luay, rear)
·î	11		30. Name and address of person who completed cause of death	/	Print) A	UUUUU		2-7-0	J. W
1	100		Brendan Kiel MD 90	DD Fran	Klinfa	nare Dri	ve Bal	to. MD	21237
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	BARLO			,, -	

			1 - For State Registrar	State of Mary		artment of			iene g.No.006	14056
	Physic /Medi		1. Decedent's Name (First, Middle, Last Walter Szpar	ia				2. Date of Deat Month May	Day 2006	3. Time of Death 9:00 P M
	Examii	ner	4a. Facility Name (If not institution, give 9105 Deborah Au 5. Social Security Number 6. Se	enue	yrs. last birthday)	4b. City, Town Notti			4c. County of Dea	imore
	Funeral Director		217-26-4296 Usual Residence of Decedent	ÂM 2□F 7		Months Da			1929 Mc	rthplace (State or Foreign ountry) Utyland
	ne Marylan 8a-f show diffed at	Director	10a. State 10b. County Maryland Baltimor		c. City, Town or Lo		ingham			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 2	al Dire	10e. Street and Number 9105 Deborah Ave	nue		10f. Zip Cod	21236	1	og. Citizen of What C U.S.A.	•
9036	ours after des rai', or items Examination	by Funeral	11. Marital Status 1 Never Married 2 💢 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 No If Yes, Give XO Year or Dates: CO	1	Was Decedent of If Yes, specify C 1 ☐ Yes 2 💢 N	of Hispanic Origin? (Juban, Mexican, Pue No <i>Specity:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural, or items 23a or 28a-1 show event, the Medical Examinational Le modified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation	16a. Dece (Give life.		cupation ne during most of wi tired) Engineer	orking	16b. Kind of Business Campbell	•
yland	e d la b	To Be C	17. Father's Name (First, Middle, Last) Frank Szpara				Rose	ame (First, Middle, A Zabrow	ski	
re, Mar	1 and Health em 27 ther tr		19a. Informant's Name/Relationship (T) Mrs. Margaret Szp 20a. Method of Disposition	ara (wife		Debora	h Avenue,	Nottingh	City or Town, State, am, MD 21 20c. Location - City or	236
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		1 🕱 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	IGINOVAL NOIN State	St. Jose	ph Ch.	Cem. 5/8	/2006 F	ullerton, Funeral Ho	Maryland
8	20 2 3		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o	ications that caused the	9	705 Bel	air Rd., i	Baltimore	, MD 21236	
	Physician /Medical Examiner the prival-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):	e 1	ives D	15 e 43 e		Onset and Death
O. Box 6	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregna Other (specify)			23d. Date of delivery Month Day	
ທົ ວ	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause	given in Part I.		acco use contribute to	o the cause of death?
	The law ate has b page 2 sł	Completed						24a. Was ar autopsy perform 1 Yes 2	/ prior to	utopsy findings available completion of cause of
Ö	Attending Physician: T r death. ector: After this certificat oy the funeral director, p	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 Nursing	Home 5 A Resider	nce 6 Other (Spe	icify)
5	tai or Attenors after death al Director: ed in by the	Certification;	3 Suicide 5 Could not be determined	28e. Place of Injury - building, etc. (Si	At home, farm, stroecify)	eet, factory, offic	ce	et and Number or Rural Route Number. State)		
	To the Hoepital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the restigation, in m	time, date and plac y opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the To the Complete	Me	29b. Signature and title of certifier	Selen	MD		os sonumber		d. Date signed (Mont	
0	A		30. Name and address of person who co Dr. Terrance Bake				ngsville.	MD 2108	7	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 20	32 Registrar's S	Signature #	W.				

				1 - For Amend Item#200	State of l	Maryla G855	nd / Dep. 5/9/<u>%</u>	artme <i>rtifica</i>	ent of He ate of D	ealth and <i>eath</i>	d Mental Hy	giene Reg. No.) 5	405	7
		Physic	ian	1. Decedent's Name (First, Middle, La Carol Catherine	st)				,		2. Date of De Month	ath Day	Year	3. Time of 0623	Death M
	1.6	/Medi Examir		4a. Facility Name (If not institution, giv	e street and numb	er)		4b. Ci	ty, Town, or I	ocation of De	May 2,		nty of Death	0623	
	450	Exami	ler	Upper Chesapeak			ter		Bel A			10.00	Harfo	ord	
	N.	Funeral Director		5. Social Security Number 6. S			s. last birthday) Yrs.	If Und Month	der 1 Year	If Under 24 H	fin. 8. Date of Bir Month, Da	v. Year)	9. Birth	place (State or ntry)	Foreign
	g			Usual Residence of Decedent											
	aryta	show a m	_	10a. State 10b. County Md. Harfor	a	10c. C	City, Town or Lo		Air				j.	10d. Inside Cit	•
	he M	or 28a-f show	Director	Md. Harfor	·u									1 🗆 Yes	2 (Z) NO
	: 1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or Itema 23a or 28a-f shov eny injury or other traumatic event, the Modical Examiner must be notified at once.	ral Dir	110 Duncannon F	load			101.	Zip Code 2101	4		10g. Citizen (S.A.	ntry?	
	ər değ	e ma	Funeral	11. Marital Status	12. Was Decede Armed Force	s?		Was De	cedent of Hispoecify Cuban,	panic Origin? , Mexican, Pu	(Specify Yes or No ierto Rican, etc.)		ace - Americack, White,		
00	36 rs aft	, a	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date			1 🗆 Yes	2₩ No	Specify:		Spe	eity: whi	te	
(1)	5-0036	atura Cal E		15. Decedent's E			16a. Dece	dent's U	sual Occupati	ion		16b. Kind of	Business/In	dustry	
ي ا	215 thin 73	Wadi	Completed	(Specify only highest gra		or 5+)	(Give	kind of DO NOT	work done du use retired)	ring most of	working	10b. Kind of	Dusinosa III	austry	
0	21.2 d wit	giene ar the	ĕ	Clementary/Secondary (5-12)	4	JI 3+)	homen	nake	r			ow	n home	2	
	פַ פַּ	al Hy 1 oth	Be (17. Father's Name (First, Middle, Last,					1	8. Mother's N	Name (First, Middle,	Maiden Sum	ame)		
9	ya Zplic	Ment arkec atic	10	William Perno						Rose	Kapustka				
106	Maryland d 2 should be file	ls m		19a. Informant's Name/Relationship (Rural Route Number			Code)	
\sim	P, P	im 27 her t		Joseph Slovick	husband	100	Place of Dispo			Road,	Bel Air,				
10	10 8	or of		20a. Method of Disposition 1 To Burial 2 ☐ Cremation 3 ☐		ite	cemetery, crei	natory o	r other place)	1	Date	Falls	ton,		
74)	Baltimore	rtmer rtant njury		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer		H:	ighview				/6/06	bel A	H, Md		
	B 8	Depa Impo eny ir	}	21. Signature of Fulleral Service Icel	5						1 Home of				
				23a. Part 1. Enter the disease, or com	plications that caus	sed the dea	ith. Do not ent	er the m	V. Mac.	Phail such as card	Road, Bel	Air,	Md. 21	014 Approximate	
	Di	nysician		fmmediate Cause (Final	one cause on each	n line.					,			fnterval Betw Onset and D	reen
	,	Medical		disease or condition resulting in death)	a. Due to (or	as a conse	quence of);	nue	r des	ne					-
	E	xaminer		Conversion the line and distance	h		,								
	70	=	ner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conse	quence of):								
1	8760, cate be executed	physicien and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c										
7	60, 8 ex	cien a		resulting in doutily East	Due to (or	as a conse	quence of):								
3/			dlcal	•	d										
39	OX 6	attending for use as	/Me	IF FEMALE:	23c. ff yes, outcor	ne of prear	nancv					004.6	N-44 4-E		
#	g ag	atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 4 ☐ Pregnant	2 🗆 Fet	aldeath 3⊑	Ectopic Other (pregnancy specify)				Date of delive Month	,	ear
	0 8	by the a	hys	9 Unknown	9□ Unknown							j			
	VISION Of VITAI RECOLDS, P.O. BOX 6 Attending Physician: The law requires that the death certif	igned be det	by Physician/Me	Part fl. Other significant conditions of	ontributing to death	n but not re	sulting in the u	nderlying	cause given	in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of de	ath2
0	Records,	been sig	ed								1 🗆 1	es 2□No	3 🗌 Prob	ably 4 🗹 Úr	nknown
aro	E CC	has be	Completed								24a. Was	an 24t	. Were auto	psy findings ampletion of car	vailable
	E P	ate ha	Ю								autop perfo 1 ☐ Yes	med	death?		12 0 01
<u> </u>	Vital	ector, p	Be	25. Was case referred to medical examiner?					2	26. Place of D	eath (Check only o				
. ~ .	Physi	n. After this certific funeral director,	유	1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpa		ER/Outpatien	t 3 🗆 [4 LI Nui Sirig	Home 5 ☐ Resid	lence 6 🗆 C	ther (Specify	()	
2	Ing F	After funera	o	27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending		njury Da <i>y</i> Yea <i>r)</i>	28b. Time of Injury		28c. fnjury a Work?		28d. Describe h	ow infury occ	urred		
· 5	DIVISION or Attending	death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be		Inium. At 6		M		s 2 No	206 L session //	Name			
Slovick	5 8	after deat Director: I in by the	Certification:	4 Homicide determined	building,	etc. (Spec	nome, farm, str fy)	eet, tack	огу, опісе		28f. Location (S City or Tox	n, State)	nber or Hura	I Houte Numb	er,
(1)	Hoapital	within 24 hours after o		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my kn	owledge, death	occurre	d at the time,	date and pla	ice, and due to the	ause(s) and r	nanner as st	ated.	
	the H	the Fi	ledical	one)	and manner	of examin	ation and/or inv	estigation	on, in my opin	ion, death oc	curred at the time,	late and place	e, and due to	the cause(s)	
	To	within 2 To the complet	Σ	29b. Signature and title of certifier					9c. License n			29d. Date sign			
	0	7		Daved 5					03:	2 5 JK.		man	2,20	000	
	6	1		30. Name and address of person who	completed cause or	f death (fte	m 23a) (Type,	Print)	,		(a) A	/	/		
)			Down S S S	N N 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	675	ature A	Def	hg. /	BEI	Air, Mc	1. 2/01	4		
		Sta Registr		31. Date filed (MATE) Dan Year) 201	Jb Jana	strar's Sign	A DO	100							

			For State	State of Ma		d / Depa	artment o		•	Hygier	⁹ 906	14058
			Registrar 1. Decedent's Name (First, Middle, La	ist)			incate	OI DealiT	2. Date o	Reg. I	No.	3. Time of Death
п	Physici		Gary John	Shumate					Month		2006	10:38 AM
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, To	wn, or Location o		- 1	4c. County of Death	
			498 Rt. 1 - Conor	wingo_Road			Conov	vingo			Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 f Under 1 Year 1 if Under 24 Hrs. Nonths Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country)									place (State or Foreign ntry)
	Director		220-40-8326 Usual Residence of Decedent	X	59	Yrs.			July	5,	1946 Mary	
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	B-fsh	ctor	Maryland Cecil		Con	owingo)					1 ☐ Yes 2 No
	or 28)ire	10e. Street and Number				10f. Zip Co			10g. (Citizen of What Cou	ntry?
	ath w	Funerai Director	498 Rt. 1 - Conor				219				USA	
	er de items	nne	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Deceden f Yes, specify	t of Hispanic Orig Cuban, Mexican,	in? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Ameri Black, White	
336	irs aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10		1 □ Yes 2 🔀	No Specify:			Specify:	White
21215-0036	72 hours after death with the Maryland "neturel", or items 23a or 28a-f show colocil Examinations to notified at	ted	15. Decedent's E	ducation		16a. Dece	tent's Usual C	Occupation		16b.	Kind of Business/Ir	
215	d within 72 ho piene. r than "netui ine Medical	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use i	done during most retired)	of working			
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Maryland	ed at a	Be	17. Father's Name (First, Middle, Last						's Name (First, Mid		,	
Ž	should band marked marked	²	John Arthur 19a. Informant's Name/Relationship (Shumate		10h Mailir	Address /S	Heler			Johnson or Town, State, Zij	
Ma	2 8 8		Grace Shumate - V								owingo, M	
ē,	is 1 and 2 of Health item 27 l		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name	of	Date		Location - City or To	
Ë	Pages nent of ant: If its arry or o		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		I _		natory or othe	' '	5/05/06	Do.	l Air, Ma	- Land
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Lice		DCI			ddress of Facility			eral Home	
m	88 18 8		(ussell Sly			13	317 Cok	esbury 1			n, Maryla	
П	**		23a. Part1. Enter the disease, or communications shock, or heart failure. List only	plications that caused one cause on each lin	the death	Do not ent	er the mode o	f dying, such as o	ardiac or respirato	y arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Dua	Jen	al C	ance	1				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	10.75						
	ix.	<u></u>	Sequentially list conditions,	b	concent	ence off-						
T	nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	220 10 (0. 000	· concoqu	onos 51).						
/ O	te be executed ysician and e burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequ	ence of):						
1760,		icai		. d								
89	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE:	-								
Вох	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal	death 3	Ectopic pregn	nancy			23d. Date of deliver	ery Day Year
o.	the a	/sic	1 Yes 2 No	4□Pregnant at t 9□ Unknown	time of de	ath 5	Other (specif	(y)		-	MOULL	Day Teal
P.O.	that the ed by detac	Ph	Part II. Other significant conditions of	ontributing to death bu	t not resu	lting in the ur	iderlying caus	e given in Part I.	23e. D	id tobacco	use contribute to the	ne cause of death?
ds,	uires sign Id be	d by	coronary arte	in disea		.	, , ,	- 3 ,		,		ably 4 Unknown
COL	w requir been s should	lete	Now- Insulin	Re sendo	7	Dial	2000 1	mellet	24a. V	has an	24b Were auto	psy findings available
Re	The la te has age 2	Completed by	1/01/	Doportion	7,0	4000		10011(0	a p	utopsy erformed?	prior to co death?	mpletion of cause of
Vital Records,		0	25. Was case referred to medical					26. Place	1 ☐ Ye of Death (Check or		lo 1 ☐ Yes	2 No
<u>_</u>	Physici this ce al direc	ToB	examiner? 1 ☐ Yes 2 ❷No	Hospital: 1 Inpatier	nt 2 🗆 E	ER/Outpatien	t 3□ DOA	Othor			6 ☐Other (Specif	y)
0	ding PI h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Descri	be how inj	ury occurred	
sio	tendi leath. Ior: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b	Α			М	1 ☐ Yes 2 ☐ N				
Division of	l or Atten after deatl Director: I in by the	Certification:	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hou (Specify,	me, farm, stre)	et, factory, of	fice		n (Street a Town, Sta	and Number or Rura te)	I Route Number,
	spitel ours ours reral filled		29a. Certifier 1 Certifying Ph	ysicien: To the best o	f my knou	viedne death	occurred at th	no time, date and	place, and due to	ho causo/	c) and manner as a	totod
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	(Check only 2 Medicel Exer	niner: On the basis of and manner stat	examınatı	on and/or inv	estigation, in	my opinion, death	occurred at the tin	ne, date a	nd place, and due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	000			4	cense number		29d. D	ate/signed (Month,	Day, Year)
}			Muer Sh	ester Or			DO	505395	25	0.5	06/10/20	06
1	,		30. Name and address of person who		ath (Item			0	C	Ina	21011	-0848
Ú			Oliver S. Thresher		7		n St.	KISING	Sur	MD	01711	-0878
	Stat Registra		31. Date filed (Month, Day, Year)	32. Redistra	rs Signati	Mr. Ag	and I					
			MAY 0 4 2	UUD		~ 17						

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John Christopher Schlavi State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Month D May 2, 2006 Medical Examiner John Christopher Schiavi 0822 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 2109 Castleton Road Darlington Harford 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours oreign Director 214-78-5327 Country) Maryland 1 X M 2 F 34 29 Mar. 1972 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Harford Darlington 1 Yes 2 X No hours after death with the Maryland Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2109 Castleton Road USA 23a notil 21034 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces 2 X Married White etc. or. Yes 1 Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year White Specify. ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ within 72 l it: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 12 Elevator Mechanic Construction 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Americo Albert Schiavi and Mental <u>Ann Geralyn Ka</u>hl ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Americo & Ann Schiavi /Parents 2113 Castleton Road, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important: injury or oth Hilltop Service Corp. 5-6-06 Donation 5 Other Specify. Towson, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland
Approximately A 21. Signature of Fu all Service License Part I. Enter the disease, or of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on ea Between Onset and /Medical a. Carbon Monoxide Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate Yes 2 V No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 Yes After 27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject breathed carbon monoxide Natura **FOUND** 1 Yes 2 V No 5 Pending May 2, 2006 0800 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 2109 Casleton Road, Darlington, MD determined (Specify) Truck Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29 Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. May 3, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) strar's Signature State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		tificate of I			ene 006	14060
	Physici /Medi		Decedent's Name (First, Middle, Las. JACQUELINE	CAROL	TREBES			2. Date of Death Month April	30, ZVS	
	Examir	er	4a. Facility Name (If not institution, give Baltimore Washin	gton Medical		Glen	Burnie		4c. County of Dea	Arundel
Ŀ	Funeral Director		5. Social Security Number 6. Security Number 15 15 16 15 16 16 16 16 16 16 16 16 16 16 16 16 16	7. Age (In ☐ M 2	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth A(Month, Bay)	(1936 Wes	rthplace (State or Foreign ountry) St Virginia
	and		Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Lo	cation				10d. Inside City Limits
	Marylan -f ehow	to	Maryland Anne A	rundel	Glen	Burnie				1 ☐ Yes 2 🛍 No
	death with the Maryland me 23s or 28s-f show	Funeral Director	10e. Street and Number 300 Blue Water Co	urt Unit 104	·	10f. Zip Code 2106	60	109	g. Citizen of What C	ountry?
215-0036	or ite	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎉 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
7.C	2 2 3	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup	ation during most of work d)	ing 16	6b. Kind of Business	s/Industry
<u>5</u>		mp	Elementary/Secondary (0-12)	College (1-4or 5+)		pervisor	3)		Motor Veh	icle Admin.
2.5 2.5	fited Hygi Sther	Be Co	17. Father's Name (First, Middle, Last)	0		per visor	18. Mother's Nam	e (First, Middle, Ma		icie Admin.
Jan	should be nd Mental marked c	To B	Andrew Go	odman			Helen	McCorn		
Mary	2 should be and Mental 'Is marked of reumstic ever		19a. Informant's Name/Relationship (T							Zip Code) 21060
	is 1 and of Health item 27 other tr		Tina M. Trebes 20a. Method of Disposition	(Daughter)					Glen Buri	nie, Maryland Town State
Baltimore,	Pege ment o ant: # ury or		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) (Cedar Hil	sition (Name of natory or other place 1 Cemete:	ry 05-0	5-06 Ba	altimore,	Maryland
Bar	permit. Departimontalismontali		21. Signature of Funeral Service Licens	500	Mc	Cully-Po	lyniak Fu	neral Hom	ne P.A. a, Marylan	ad 21122
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cor	Smy	ngen	~ 6			
68760, <	tificate be executed ig physicien end as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a cord.	nsequence of):					
P.O. Box 68	requires that the death certific een signed by the attending pl nould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
	w requires that to be signed by should be detail	<u>م</u>	Part II. Other significant conditions co	entributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba		to the cause of death?
Division of Vital Records,	The law ate has b page 2 st	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one)		
of	this this	ဥ	1 Yes 25 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 Isuising no	me 5 Residen	ce 6 Other (Sp.	ecify)
O	fe fe	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	28c. Injun Work	k? Yes 2 □ No	200. Doscribo non	injuly occurred	
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		At home, farm, str pecify)			28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	Hospita 24 hours Funerei letely filler	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	/sician: To the best of my iner: On the basis of exa and manner stated.	knowledge, death mination and/or in	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	mD		29c. Licens	e number	290	d. Date signed (Mon	th, Day, Year)
	6		30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type,	Print)	N	((0	R	100 \$
	3		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature Signature	oital	br-1	7/1	DMNI	/ VOD
	Sta Regist	-	or. Date med (worth, Day, 18al)	52. Registrar s s	M A	Early 1				
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			1 - For State Registrar	State of Marylan		artment of F			Reg. No.	1406		
,	Physic /Medi	cal	Decedent's Name (First, Middle, Last) Rodney Talley As. Facility Name (If not institution, give)			4h Cib. T		2. Date of De Month	25 200	06 11:20 M		
, 	Examir	ner	5. Social Security Number 6. Sep	L OF BALTI		4b. City, Town, o BATT If Under 1 Year	I MOR	E C17	4c. County of D	eath Birthplace (State or Foreign		
ļ	Funeral Director			9M 2□F 77	Yrs.	Months Days	Hours M	in. (Month, Da Nov. 5,	ly, Year)	(laryland		
	death with the Maryland ime 23a or 28a-1 show in must be notitied at	ector	MD 10e. Street and Number		timore				10 00	10d. Inside City Limits 11 Yes 2 □ No		
	23a or	ai Dir	3405 Keston Road			10f. Zip Code 21207			10g. Citizen of What USA	Country?		
		by Funeral Director	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ঐYes 2 □ No If Yes, Give Year or Dates: 1950	It	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No erto Rican, etc.)	Black, W Specify:	merican Indian, hite, etc.		
0-617	filed within 72 hours after Hygiene. other then "natural", or Ite ent, the Medical Examina	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. [ent's Usual Occup kind of work done OO NOT use retired	during most of w	vorking	16b. Kind of Busine			
מוות ע	should be filed vind Mental Hygie markad other timatic avent, to	To Be Co	o no 17. Father's Name (First, Middle, Last) Linwood Samuel Ta	11ev	Elect	rician H	18. Mother's N	lame (First, Middle,	, Maiden Sumame)			
~	and Marian	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street			er, City or Town, State	, Zip Code)		
, ע	permit. Pages 1 end z Department of Heelth a Important: if Item 27 is any Injury or other tra ance.		Dorothy Talley/sp 20a. Method of Disposition 1 Burial 2 Cremation 3 B 4 Donation 5 Other (Specify)	20b. PI	ace of Dispos	Keston Ro sition (Name of latory or other place		imore, MD	21207 20c. Location - City	or Town, State		
Dall	Departm Departm Imports any Inju		21. Signature of Funeral Service License	wade, Director	St	Name and Address ate Anat	omy Boa	rd 655 W.	Baltimore	Street		
	hysician /Medical Examiner		23a. Pa 1. Enter the disease, or or mplishow, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	calions that clused the death le cause on each line. S'two	Re	er the mode of dyin	g, such as card	ac or respiratory ai	rrest,	Approximate Interval Between Onset and Death		
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	by the attending phase had for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year		
- 1	been signed b	þ	Part II. Other significant conditions con	tributing to death but not resu	Iting in the un	derlying cause give	en in Part I.			to the cause of death? Probably 4 Dunknown		
		Completed			· · · · · · · · · · · · · · · · · · ·				an 24b. Were prior to death 1 1 Ye	autopsy findings available o completion of cause of ?		
	ter this	tion; To Be	27. Manner of Death 1 Patural 5 Pending		ER/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 🗆 Nursing		ne) dence 6 □Other (Sp now injury occurred	pecify)		
	within 24 hours effector: A completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town)							treet and Number or Rural Route Number, n, State)		
10007	24 hour Funar etely fill	edicai	29a. Certifier 1 Lertifying Physical (Check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	rladge, death on and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occ	be, and due to the courred at the time, o	date and place, and d	us stated. ue to the cause(s)		
Ç	within To th compl	Me	29b. Signature and title of certifier	MD.		29c. License	_		APRIL Z			
			30. Name and oddress of person who cou	mpleted cause of death (Item	23a) (Type, F	Ho SP1	TAZ	OF B	AZTIMON	5, 2006 RE		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 20	32 Registrar's Signatu	ILE .	well o						

TALLEY, RODNEY

Patient known

Please Type or Print in Black Indelible Ink Robert Lane Tillman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 2109 hrs May 1, 2006 Robert L. Tillman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8217 Mill Field Court Millerville Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) **Funeral** Days oreign Months Hours Min Director 500-70-8470 1 X M 2 47 Country) Oct. 14, 1958 MO. Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits 23a or 28a-f show notified at once. MD 1 Yes 2 X No Anne Arundel Millersville ggs I and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene.

1 filten 27 is marked other than "natural", or items 23a or 28a-f she ther transmatic event, the Medical Examiner must be nofffed at once. irector 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? ö 8217 Mill Field Court 21108 U.S.A. Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White, etc. 2 X No Yes f Yes, Give Year Widowed Divorced Yes 2 X No specify Specify white ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 Computer Hardware Supporter Computers 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Arthur R. Tillman Gloria Ferretti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Tillman / wife 8217 Mill Field Court; Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State at. Pages | z crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from State May 3, Donation 5 Other Specify: Chesapeake Cremation 2006 Stevensville, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Singleton Funeral Home, PA Second Ave SW; Glen Burnie, MD 21061 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Head Injuries a. Intracerebral Hemorrhage Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and AMENDED item#23a,PII,27,28a-f,perME,g857,7/20/06 Tt g UNPENDED attending physician or use as the burial Physician/Medi or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Chronic alcoholism 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? . death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ lospital: 1 Inpatient 2 Nursing Home 5 this ER/Outpatient 3 DOA Residence 6 V Other: Scene 1 V Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: t 24 hours after death.

Funeral Director: A etely filled in by the fu Pending 1 Yes 2 No unk subject fell 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) determined (Specify) unk Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only within To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Lo and manner stated dure and title o 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 2, 2006 Ì 000

State Registrar

111 Penn Street, Baltimore, MD 21201

ame and address of person who completed cause of death (Item 23a)

4

Assistant Medical Examiner

Laron Locke MD.

31. Date filed (Month, Day, Year)

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	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State		r, crematory`or		Date		Location - City or					
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Tire.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A.												
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Ped	one)	and manner stated	1.										
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State Registrar Name and addres

31. Date filed (Month, Day, Year)
MAY 0 4 2006

DHMH 17 Rev 1/2001

Phys /Me Exar

Funer Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Itsm 27 is marked other than "natural", or Items 23s or 28s-f ehow any injury or other traumatic event, it a Medical Exaction must be published at

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JAVIER VALIQUE

Baltimore, Maryland 21215-0036

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06-02948 Denise West

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State of Maryland / Department of Health and Mental Hygiene

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29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Sord law rec has bee	ple		auto	osy prior to				
29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Re(: The fficate			1 🗸 Yes		es 2 No			
29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	/ital		examiner? [Hospital: 4] Least of ED/O Letter 2] Dother.		Residence 6 Othe	<u> </u>			
29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	of \ ng Phy Nfter th	-1	27. Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?			···			
29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ion ttendin tor: A	atio	Natural 5 Pending 1/27/2006 A 1.001 Yes 2 N	subject	involved in ho	use fire			
29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Divis ital or Av ars after or ral Direc	ertific	3 Suicide 6 Could not be determined (Secretary of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town, S	Street and Number or Ru State) 8 Glenwood	et and Number or Rural Route Number, City			
29b Signature and title of certifier O.C.M.E. May 2, 2006 30. Name and address of person who completed cause in h (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	thin 24 ho the Fune the Fune	se(s) and manner as started							
30. Name and address of person who completed cause with (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	F 3 F 3	Me	29b Signature and title of certifier 29c. License number		29d Date signed (Mo	nth, Day, Year)			
	WI		Theda M. Lath wo O.C.M.E.		May 2, 2006				
	RO ONT	Ī	· /amount	MD 21201					
State 31. Date filed (Month, Day, Year) Registrar MAY 0 4 2006		ate	31. Date filed (Month, Day, Year) 32. Jegistrar's Signatule						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RI ATERS Min 2016 06/1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Sex 12 M 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 215-26-3559 79 Yrs. AUG 9, 1926 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Director Virginia Fairfax Annandale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4589 Logsdon Drive 22003 USA death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □XYes 2 □ No WWII
IYes, Give
Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite nay injury or other traumatic event, the Medical Examina 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: ģ 3 ☐ Widowed 4 【XDivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Drywall Finishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Elbert Waters Ella Belle Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22181 19a. Informant's Name/Relationship (Type, Print) Sandra Waters-Levy/Dauchter 9480 Virginia Center Blvd, Unit 403, Vienna, VA
Date Olisposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/4/06 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Fun ral Service Licensee

22. Name and Address of Facility Cremation So

23. Part A. Gregorchik

23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sto meta **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No М 2 Accident investigation Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of entities 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person ed cause of death (Item 23a) (Type, Peter comp a 31. Date filed (Month, Day, Year) Megistrar's Signature 4 2006 Registrar MAY 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 10:40 pm Joseph Wood Apm 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner southern Manyland hospital Pnnco Canhon, George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number & Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **XX**M 2□ F 579 28 7497 Yrs. Director Feb 10, 1927 Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ehow If a Medical Exerticational to notified at 1 | Yes 2 | No XX Directo Maryland | Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 14611 Mount Calvert Road 20775 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XX Married 1 ☐ Yes 2 🗓 Xo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event page. Joseph E. Wood, Sr. Nellie M. Clinkscales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20775 Ruth H. Wood (wife) 14611 Mount Calvert Road, Upper Marlboro, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 📉 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory May 2, 2006 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home Inc. 6633 01d 21. Signature of Funeral Service Licensee MO1457 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) renal Acute anmo **Physician** 7 den 18 /Medical Due to (or as a consequence of): Examiner Dehydra hon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor sequence of). Examine 2 months use as the burial-transit concinoma and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy page 2 should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Mnknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 In atient P 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

DX State

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

within 72 hours after

Baltimore, Maryland 21215-0036

SHRI 31. Date filed (Month, Day, Year)

MAY 0 4 2006

aman

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 32. Registrar's Signature

SURRAIS

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CLINTON, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔒 🗎 For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** 00 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner TARBOR TIMOR
If Under 24 Hrs. If Under I Year (În yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 PTF 488-20-8436 Usuel Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at MD. 1 Pres 2 No TIMORE Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5.A 300 NOOD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 400 If Yes, Give Year or Dates: 21215-0036 1 Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) KER OWA 7 is marked other traumatic event, 1 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Jury or other traumatic event once. Be 1 NOWN ၉ 19a. Informant's Name/Relationship (Type, F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OMM.ON BELLOMY BALTO, MD. 2/201 Baltimore, 201. Place of Disposition (Name of competery, crematory or other p PRIL 26 20c. Location - City or Town, State Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State CODLAND 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2829 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hyportenine Arterioscloubie Coronay VAxobr Dienne **Physician** year? /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ettending physician and for use as the burial-transit be executed Due to (or as a consequence of): Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e P.O. Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ deorenhon ficate hes been sign, r, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Shknown Completed old ocretrousular eccident 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate diadetes. 1☐ Yes 2 -NO of Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospiror ...
within 24 hours after death.
To the Funeral Director: After this c 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospitel or Attending 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAY 0 4 2006

Our wor

30. Name and add s s of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Will Som

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Cheerahren -

DHMH 17 Rev 1/2001

29c. License number

D19667

7310 Petaline Holmany #508 Glen Borine, Mariland 21061

29d. Date signed (Month, Day, Year)

04-21-2006

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4)OLFRAM Month Year **Physician** RICHARD 8:15 MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊊ M 2□ F 217-52-7740 Yrs Director July 3, 1950 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1015 Upton Rd. 21060 USA Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Pitt Ohio Express i. Pages 1 and 2 should be filed witnent of Heelth and Mental Hygien tant: if item 27 is marked other the jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto F. Wolfram Lodema L. Ballantine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Wolfram - wife 1015 Upton Rd, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 5/4/2006 Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death GASTRIC CANCER Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** 5 MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) bed f o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes ₽ No 1. Inpatient 2 ER/Outpatient 3 DOA Yo the riversal within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Pertifying Physician: To the best of my knowledge, death corumed at the time, date and plans, and due to the cause(s) and numer as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number INTERN RES 00 MIAY, 2, 2006 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225 82. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cecilia Wray April 30 2006 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Nottingham
If Under 1 Year If Under 24 Hrs. 8815 Blairwood Rd., Apt. T2 Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Months Days Hours Yrs. Director 214- 62-9587 Oct. 27.1952 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked othar then "natural", or items 23a or 28e-f show traumatic avant, it e Madical Examiner must be maiffied at 1 ☐ Yes 2 ☑ No Director MD Baltimore Nottinaham 10e. Street and Number 10g. Citizen of What Country? Of, Zip Code Blairwood Rd., Apt TZ

12. Was Decedent Ever in U.S.
Amed Forces? 8815 21236 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygiene
Important: If itam 27 is marked other the
any injury or other traumatic avant, ILEL
00028. Administrative Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley Haleski Dorothy Wray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Landrum Ct., #303, Parkville, Md. Mrs. Jacqueline Bryant (dgtr) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5/2/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee Schimunek Funeral Homes Kum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line. Road, Baltimore, Md. proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andro rulmo very Pnysician /Medical Due to (or as a consequence of): **Examiner** Due to (or a) a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Litectopic pregnancy Live Dirin ∠ ∐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan autopsy performed? 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🕱 No 10 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) within 2 and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 51,100 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4136-B East Joppa Rood Balto. 21236 Morrill, m.D 39. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY Q 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month William C. Wilburn, Jr. 6:25AM 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Roland Park Place Health Care Center N/A Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **X** M 2□ F 423-03-3708 Alabama May 1, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Specify: White 16b. Kind of Business/Industry US Navv 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 W. 40th Street Apt. 802 Baltimore, MD 21211 20c. Location - City or Town, State Catonsville, MD 22. Name and Address of Facility Burgee—Henss—Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Between Onset and Death Hypertensive Cardiavaseular disease years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The SPETAR. TOO W. 40 M STREET, BALTIMORE, MD 21211 31. Date filed (Month, Day, Year) 32 Registrar's Signature Goods! MAY 0 4 2006

19

State

Registrar

Physician

/Medical

Examiner

Funeral

Director

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:04 PM JOHNNIE JANUARY WASHINGTON , 2006 Z /Medical 4a. Facifity Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS BATVIEW MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12-28-35 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F 216-30-9824 Md. Director 70 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State 27 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Madical Examinat must be notified at 1 Yes 2 □ No Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 2328 Barclay Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ 2 ▼No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 Widowed 4 Divorced pernit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturany njury or other traumatic events." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Laborer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Watson Washington, Sr. Geneva Johnnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 Brendan Avenue, Baltimore, Md. Sheila Brady Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cem. Anne Arundel Co., Md. 1-7-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. Branefor Millon 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMMORRHAGIC **Physician** GASTRIC HOURS resulting in death) /Medical Due to (or as a consequence of): Examiner SALMONELLA WEEK SEPTICEMIA Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury TION APPROVED BY THICAL EXAMINER Due to (or as a consequence of): Examine as the burial-transit requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending | IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of deliver 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown HOUSEFIRE WITH SUPERFICIAL BURNS TO FOREHEAD AND SCALP peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 has certificate 1 Yes 2 No Division of Vital or Attending Physiclan: ector, Be 25. Was case referred to medical 26. Pface of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending death. 1 Yes 2 No investigation HOUSE FIRE 2 Accident 10 filled in by the DECEMBER 19, 2005 within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Pface of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide HOME 3512 BRENDON AVE, BALTIMORE the Hospital 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies E.S. Autul M.D. RES -006 JANUARY 11. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN BALTIMORE, MD 21224 EMMANUEL 5. ANTONARAKIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Dependment of Heath and Mental Hygiene. Dependment of Heath and Mental Hygiene. Important: If item 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Exercine must be notified at ance. To Re Commission by Elizara Director	3 ⊠ Wi	ever Marrie	ed 2□ Mari	rried	12. Was De Armed F 1 ☐ Yes If Yes, G Year or	orces? 2∭ Na ive			Was Daced If Yes, spec 1 ☐ Yes 2		ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		ck, White,		
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			Registrar 1. Decedent's Name (First, Middle, Last)				2	. Date of Death			3. Time of Death
	Physicia		August P. Zajac					Month	Day	Year	1 - 20 D M
	/Medic		4a. Fecility Name (If not institution, give street	and number)	4b. City, Town,	or Location of		pril :	30 , 2 (4c. County	0.06 of Death	1:30 P M
	Examin	er		and trainibory		_					
			2901 Yorkway 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Dundal If Under 1 Year		24 Hrs. 8	. Date of Birth		9. Birtho	
	Funeral Director		173-14-3182 1EM 2		Months Davs	Hours	Min.	Date of Birth Month, Pay,	1°9′22	Co <i>u</i> in	place (State or Foreign htry) PA
			Usual Residence of Decedent								
	/lanc		10a. State 10b. County	10c. City, Town or	Location					1	0d. Inside City Limits
	Mar 1-1-8-1	ţo	MD Baltimore	Dunda1	k						1 ☐ Yes 2 No
	r 28¢	lrec	10e. Street and Number		10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	within 72 hours after death with the Maryland ene. then "neturet", or itams 23a or 28a-f show the Medical Evandaric must be notified at	Funeral Director	2901 Yorkway		212	22			USA		
	deat	ner	11. Marital Status 12. W	as Decedent Ever in U.S. 1 med Forces?	3. Was Decedent of If Yes, specify Cub	Hispanic Orig	in? (Speci	fy Yes or No-		e - Americ	
9	after or its	F	1 Never Married 2 Married 1	XYes 2 □ No Ass, Give	1 ☐ Yes 2 ☒ No		, , , , , , , , , , , , , , , , , , , ,			y: Whi	
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ည်	72 h natu	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a. De	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most	of working	,	6b. Kind of B	usiness/Ind	dustry
21	ithin ne.	du		llege (1-4or 5+)							
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밀	should be filed within 72 hours after death with the Marylar of Mental Hygiene. markad othar than "natural", or itams 23a or 28a-1 show matte evant, the Medical Evantual matte evant.	Be	17. Father's Name (First, Middle, Last)				,			10)	
3	should ind Men marka umatic	2	Antonio Zajac					Kurchu			0-41
Baltimore, Maryland 21215-0036	- m -		19a. Informant's Name/Relationship (Type, Pr	int) 19b. M	ailing Address (Stree	t and Number		en Bur	-		
0	permit. Pages 1 and 2 Depirtment of Health s Important: If itam 27 li any injury or other tra		Mary Rattell - Da	ughter 1 (TECDWOO sposition (Name of	d Ave	Dai		Oc. Location		
9	of H of H if ita		20a. Method of Disposition 1 ☐ Burial ※☐ Cremation 3 ☐ Remov	al from State cemetery, o	crematory or other pla	ace)				•	
Ξ.	Pag ment ant: ury c		' 4 ☐ Donation 5 ☐ Other (Specify)	Bayvi	ew Crema						
at	Depart Import any nj		21. Signature of Funeral Service Licensee								eral Home,
<u>m</u>	82559		That the		PA, 2134					212	2 2 2
760,	Provided in the provided provided in the provi	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	(Ve	, 30011 43 5			5 ,		Approximate interval Between Onset and Death 30 minutes
P.O. Box 687	i the death certificate by the attending phys ached for use as the	Physiclan/Medic	in the past 12 months?	Pregnant at time of death Unknown	3 Ectopic pregnant 5 Other (specify)			23a Did tob	Mo	ate of delive	ery Day Year he cause of death?
	w requires that been signed I should be det	d by	Ity pertension	ing to death but not resulting in th	e underlying cause g			'	s 2 🗆 No		/
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/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	NI:		thorn		Check only on			
	hys his	2	1 Yes 2 No	1 Inpatient 2 ER/Outpa	Illent 3 DOA	4 🗆 Nui		e 5 🗖 Reside			fy)
u u	Ing P	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	a. Date of Injury 28b. Tim (Month, Day Year) Inju	ry We	ork?		d. Describe ho	w injury occur	red	
Sio	Attanding r death. actor: After by the fune	catl	2 Accident investigation			_Yes 2 □ N	-	V Laustine (Ct		h	- / Paris Africa
Division of	at or Attanding P after death. I Diractor: After t d in by the funera	Certification	4 Homicide determined 28	 Place of Injury - At home, farm building, etc. (Specify) 	, street, factory, office	9	28	City or Town		er or Hura	al Route Number,
	Hospita 4 hours Funara ely fille	edical C	(Check only 2 Medical Examiner: C	To the best of my knowledge, don the basis of examination and/ond manner stated.	eath occurred at the or investigation, in my	time, date and opinion, deat	d place, an	nd due to the ca	use(s) and mate and place,	anner as s and due to	stated. o the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier			nse number			d. Date signe		
			M. 10 m. Chattan	- MD	D.	51185	Ś	1	nay	1,2	006
	10		30. Name and address of person who complete	ed cause of death (Item 23a) (Ty	pe, Print)	J. ()	/	R. 1	1100000	m.	21224 england
	Sta	ate	Colleen Chinstones 1 31. Date filed (Month, Day, Year)	ND 6505 Hop 32 Pegistrar's Signature	ins Day	1, ewc	UTCLE	1 Jal	nnore	,100	ryuna
	Regist		MAY 0 4 2006	Brown Ir	South?						

		•	State of Maryland / Der 1- State Amend Item 23a per Dr., G856, Q6	partment of Health and I 173 (16dh) Hillicate of Death	Mental Hygie	ne) () 6	14075
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Vans	3. Time of Death
	Physicia		Paul M. Anderton		April 17	7, 2006	1:54 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
н			Anne Arundel Medical Center	Annapolis		Anne Aru	ndel
	Funeral Director		5. Social Security Number 217–24–3614 6. Sex 2 F 7. Age (In yrs. last birthda) 77 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 2-3-1929	ear) 9. Birthy Coul	place (State or Foreign ntry) yland
	0		Usual Residence of Decedent				10d. Inside City Limits
	show	_	10a. State 10b. County 10c. City, Town or				1 X Yes 2 □ No
	Ba-f	Director		napolis	100	. Citizen of What Cou	ntn/2
	with t	直	1601 Bay Ridge Ave.	10f. Zip Code 21 403	109.	USA	nuy.
	ss 23	era		. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ameri	can Indian,
36	be filed within 72 hours after death with the Maryland ntal Hygiene. Adother than "natural", or Itams 23a or 28a-f show avant, the Modical Examinar must be notified at avant, the Modical Examinar must be notified.	by Funeral	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced Year or Dates: 1946–48	If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 XNo Specify:	o Rican, etc.)	Black, White,	
Maryland 21215-0036	2 hou atura		15. Decedent's Education 16a. Dec	edent's Usual Occupation re kind of work done during most of wor	ting 16	b. Kind of Business/In	dustry
215	within 7 iene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	King	- 1	
2	e filed within al Hygiene. I other than '	S	5+ Lawy			Legal	
nd	be fill tal Hy d oth avant	Be	17. Father's Name (First, Middle, Last)		ne <i>(First, Middle, M</i> a. her Busey	iden Sumame)	
<u>\Z</u>	should be and Mental s marked o	P	Marshall H. Anderton	lling Address (Street and Number or Ru		Titure Tourn State 7i	Codel
Mai	s 1 and 2 should f Health and Mer itam 27 Is marke other traumatic	9 0	1.11	Bay Ridge Ave.,			3 0000)
	1 and Healt am 2		20a Method of Disposition 20b. Place of Dis	position (Name of		c. Location - City or To	own, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra ance.	1	1 Burial 2 XCremation 3 Bemoval from State	ematory or other place) cematory 4-1	9-06 Ed	dgewater,	MD
Ħ	nit. Partme ortan injur			22. Name and Address of Facility G		-	
Ba	permi Depa Impo any id		· Millul	2973 Solomons Isl			
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ó	an an irial-tr	Ex	resulting in death) Last Due to (or as a consequence of):				
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<u>α</u>	res that igned b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	
rd	v require been sig should b				1 🔲 Yes	2/2 No 3 ☐ Pro	bably 4 □Unknown
Records,	The faw rec ate has beer page 2 shou	ompleted			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		ath (Check only one)		
of V	dils dil	2	1 Yes 2 No Hospital: 1- Inpatient 2 ER/Outpat				fy)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
Sio	ar or:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f. Location (Street	et and Number or Rur	ral Route Number.
Division	il or Attand after death Diractor: /	Certification;	4 Homicide determined 256. Flade of Injury Actionic, family, building, etc. (Specify)	street, ractory, office	City or Town, S	State)	
	To tha Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	edical C	29a. Certifier (Check only one) 1 Certifying Physician: to the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
)	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	290	1. Date signed (Month)	CC6
			30. Name and aderess of person who completed cause of death (Item 23a) Typ	e-Print) COR	MARY	Av An	nipils m
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1		/
	Registr	ar	APR 1 9 2006	doubs .			

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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al Exami	Wanda H. 4a. Facility Name (if not institution, give street and number)]	Beetham	4. 00.			(D II	April 17	2006			0734 h	nrs
)		4a. Facility Name (if not 8600 Jones Mil			treet and ni	umber)				own, or L Chase		f Death		ľ	4c. County of Montgor		1	
Funeral		5. Social Security Numb	er	6. Sex		7. Age	(In yrs. last	t birthday)		r 1 Year	If Under		8. Date of	Birth(MI	M/DD/YYYY	9 Bir Foreig	thplace (Stat	te or
Director		204-10-9300		1 M	2XXF		87	Yrs	Month	Days	Hours	Min.	Aug. 1	2, 1	918	Co	^{untry)} Penr	ısylva
ži.		Usual Residence of Dec 10a, State 10b.	edent County			14	Inc. City. To	own or Locat	ion.								10d Inside	
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ryland a-f sh t once	ctor	Maryland P	ГПС	e Geor	ge s		FOI	restvil]	Le 10f. Zip	Code				10a C	itizen of Wh	at Cou		XX
be filed within 72 hours after death with the Maryland and Hygiene Han "natural", or items 23a or 28a-f show any refe other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Director	6715 Lansd	ale S	Street	_				101. 2.1	2074	4 7			l log o	USA		, a y .	
with t		11. Marital Status		1	2. Was Dec		ver in U.S.						cify Yes or	No-	14. Race	- Amer	can Indian, E	Black,
or iter	Funeral	1 Never Married	2 XXX	larried	Armed F		X No	If Y	es, speci	y Cuban,	Mexican,	Puerto R	tican, etc.)		White			
ral",	by	3 Widowed 4	Law-1		Yes, Give Yes Dates:			-		XX No					Specify:		hite —	
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Id De filled within 72 hours after Aental Hygiene narked other than "natural", event, the Medical Examiner	Completed	12	y (0 12)		Conoge (1 4 01 0	'	Но	omemak	er					In H	Tome		
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	7	19a Informant's Name/F						19b. Mailing							City or Tow e 1995		, Zip Code)	
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Department of Heal Important: If iten injury or other tra		4 Donation 5 21. Signature of Funeral	Other S Service	<i>pecify:</i> License	- / -			122 N	lame and	Address r	of Eacility							
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sician		23 Fart I. Enter the dis failure. List only or	ease, or e cause	complix on each	tions that of	aused t	he death. D	o not enter th	ne mode	f dying, s	uch as ca	rdiac or i	respiratory a	arrest, s	hock, or hea	art	Approxima Between	
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	iciar	past 12 months?					ime of death	h	tal death her (Spe	3 <u></u>	Ectopic	pregnan	СУ		Month	L	Day	Year
ine taw requires that the death cert cate has been signed by the attendir page 2 should be detached for use a	hysi	1 Yes 2 V No 9			9 Unkn						- 0.5							
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e = 2 = 5	edical (,						, death occur /or investigat										
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03		30. Name and address of	f person	who con	nplet d	se of de	aller Item 2				_				10, 20			
100		Theodore King			tant Med			111 Pe	nn Stre	et, Balti	more, I	MD 21	201					
	tate	31. Date filed (Month, Da			. R	egistrar's	s Signature	-										
Regist	trar	APR 2	0 2	006	J. Charles	1000	1	And the										
1/ Rev 1/2	100							ORIGINA	L									

			1 - For State Registrar	State of M	laryland / D	Departm Certific			Mental H	ygiene Reg. No	UUU	14077
	(3s) (3s)		1. Decedent's Name (First, Middle, L	ast)					2. Date of I	Death Da	v Yeer	3. Time of Death
	Physici /Medic		Robert	Burns					Apri1	20,	2006	7:42A M
	Examin	er	4a. Fecility Name (If not institution, g		7)			or Location of Dea	th		: County of Deat	h
		J- \$	Civista Medical		ge (In yrs, last birt		La Pla		s. 8. Date of E		Charles	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. 577 – 28 – 0453	1 X M 2□ F		Yrs. Mon		Hours Min	Sept.	Day, Year)	Co	untry) (ryland
3			Usual Residence of Decedent		02				эсре.	т, т.	323 HO	try rana
9	rylan	_	10a. State 10b. County		10c. City, Town	n or Location						10d. Inside City Limits
3	ith the Marylar or 28a-f ehow	Director	Maryland Prince	George's		Brand						1 ☐ Yes 2√ No
Burne	vith th	Dire	10e. Street and Number			101	f. Zip Code				tizen of What Co	untry?
3	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. le marked other then "naturel", or Items 23a or 28a-f ehow raumatic event, the Marcical Examiner matter the Intified at	Funeral	15509 Baden Naylo	r Road	t Ever in LLS	13 Was D	20613		Spacific Vac or I		.S.A. 14. Race - Ame	rican Indian
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces	?	If Yes,	specify Cub	Hispanic Origin? (an, Mexican, Pue	rto Rican, etc.)	10-	Black, White	
936	urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates		1 □ Y	es 2 X No	Specify:			Specify: W	nite
Rober 21215-003	within 72 hours after ene. then "naturel", or Ite	Completed	15. Decedent's (Specify only highest g	Education	16a.	Decedent's	Usual Occup	pation during most of wo	odkina	16b. K	(ind of Business/	Industry
22	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or		life. DO NO	OT use retire	ed)				
₹	filed w Hygier other th		9 17. Father's Name (First, Middle, Las		Spe	ecial	Transi	fer Clerk	ame (First, Midd			Service
and	be fi	Be		31)							n Sumame)	
<u> </u>	should nd Men marke umatic	ဥ	Harry Burns 19a. Informant's Name/Relationship	(Type Print)	19h	Mailing Ado	trace /Strace	Alberta	Rucker	her City	or Town State 2	Zip Code) 20613
Baltimore, Maryland	ges 1 end 2 should be filed within 72 hours after death with the Maryla t of Health and Mental Hygiene. If item 27 le marked other then "naturel", or Items 23a or 28a-f ehor or other traumatic event, I'm Medical Examinar mast Le mailited at		Shirley M. Burns		15			Naylor R				
ම	permit. Pages 1 end 2 Department of Health a Important: If Item 27 le eny injury or other tra ance.		20a. Method of Disposition	wije	20b. Place of cemeter	Disposition	(Name of	naytor R	Date Dic		ocation - City or	
JO I	ages ent of nt: If i		1 Durial 2 Cremation 3 4 Donation 5 Other (Spec		0				oe onne	Cho	Itonkan	. Maryland
謹	artm. Fortar		21. Signature of Funeral Service Lic			22. Nam	e and Addre	ess of Facility			ASHINGTO	
ñ	Depa Impo eny i		Mark M. Is	Janus 2	,	Hunt	t Fune	ral Home				MD 20604
	6 - A		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ed the death. Do n						•	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		PSIS							Onset and Death
	/Medical		resulting in death)	a	s a consequence of	of):						
	Examiner		Sequentially list conditions,	bB		moni	a					
	pe #is	lne	if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury		s & consequence d		escar! a					
_	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	INOM 600	of):	0116					
8760,	cate be executed physician and the burial-transit				VA	,						
687	ficate p phys	Physician/Medical		d.								
Box 6	leath certifica attending ph I for use as tl	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		2 🗆 🗆					23d. Date of del	ivery
ă.	The law requires that the death certite has been signed by the attendinage 2 should be detached for use	lcla	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant	2 Fetal death at time of death		oic pregnance or (specify) _	:y 		-	Month	Day Year
P.O.	at the by th	hys	9 Unknown	9∐ Unknown								
s,	es tha	by F	Part II. Other significant conditions	contributing to death	but not resulting in	the underly	ing cause gr	ven in Part I.			,	the cause of death?
ord	w require been si should I	ted							11	Yes 2	No 3□Pr	obably 4 Unknown
ec	law law las b	Completed							24a. Wi au	topsy	24b. Were au	topsy findings available completion of cause of
=	sicien: The lav certificate has rector. page 2	Con							1 ☐ Yes	rformed?	death?	2 □ No
Vits	Physicien: this certification and director.	Be	25. Was case referred to medical examiner?	Hospital:			0.	han	eath (Check onl			
o	Phys this ald	.T	1 ☐ Yes 28 No 27. Manner of Death	Inpai		tpatient 3	JOUA		Home 5 ☐ Re		6 ☐Other (Spe	cify)
Division of Vital Records,	ding F h. After funer	tion	1 Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, D	lay Year) Ir	njury M	28c. Inju Wo	ork?]Yes 2 □No	230. 2000.12	o non inje	.,	
isi	Atten deat octor: y the	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of I	njury - At home, fa	ırm, street, fa	_1					ıral Route Number,
Ö	after Dire	Certification:	4 Homicide	building,	etc. (Specify)				City or 1	Town, State	θ)	
	To the Hospitel or Attending Physicien: The lawinin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director. page 2	edical (29a. Certifier 1 Certifying ! (Check only one)	Physician: To the beseminer: On the basis and manners	of examination and	e, death occu d/or investig	rred at the tation, in my	ime, date and place opinion, death occ	e, and due to the	ne cause(s e, date an	s) and manner as d place, and due	stated. to the cause(s)
	To the within Fo the complex c	₩	29b. Signature and title of certifier	AA N			29c. Licen	se number			ate signed (Monti	
			Munce	MD			D-0	057999		4	420106	
0			30. Name and address of person wh	o completed cause of	death (Item 23a) ((Type, Print)	0	///		1		
	DB 10=1		Manisha J. Jariw	ala, MD 11	637 Terr	ace Di	rive,	Ste. 103	, Waldo	rf. N	Marvlnad	20602
ä	Sta		31. Date filed (Month, Day, Year)	32. Figis	trar's Signature					, .	j ===c	
	Registr	ar	APR 2 1	ZUUD Z	wa St	Cook	A Second					

Amended Item 26 per Physician 04/19/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** BRATHUHN 9:50 PM AURETTA ARLIANA 2006 16 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 25 F 213-60-9614 Director 86 10-12-1919 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15012 Dover Road 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William DeWolfe Laura Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15236 Dover Rd., Reisterstown, MD 21136 Heather Lambert - Daugh. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Pleasant Grove Cemetery 04-19-06 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee MOO550 934 S. Main St., Hampst 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 934 S. Main St., Hampstead, MD 21074 Approximate Interval Belween Onsel and Death Immediate Cause (Final MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) 2 HOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No : After this certifical funeral director, I 25. Was case referred edical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No М investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier on Mall mo D0059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 STONER AVE SUITE FOR WESTMUSTER, MD C. ABEL MD 32. Registrar's Signature

Registrar

31. Date filed (Month, Day, Year)

2006

28a-1 show

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or items 23a

within 72 hours after

The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

Hospital or Attending Physicien:

hin 24 hours after death. the Funeral Director: A

To the I wi hin 24 To the F

NJL

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

		•	. 101	artment of Health and Me rtificate of Death	ental Hygien	HIID I	4079
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	ay Year	3. Time of Death
	/Medic		William Joseph Bradford		April 18,	2006	8:15 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			2913 Lock Haven Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Ijamsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederic	
	Funeral Director		579-54-3421 1 M 2 F 64 Yrs.	Months Days Hours Min.	Month, Day, Year) Counti	nce (State or Foreign ny) ngton D.C.
	D		Usual Residence of Decedent				
	arylar ehow	_	10a. State 10b. County 10c. City, Town or L			10	d. Inside City Limits
	889-f	Director	Maryland Frederick Ijams 10e. Street and Number		140.0		1 ☐ Yes 2√ No
	with t		2913 Lock Haven Court	10f. Zip Code	10g. C	itizen of What Count	•
	ne 23	Funeral		21754 Was Decedent of Hispanic Origin? (Spec	eify Yes or No-	U.S	
0	or iter		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No !! Yes, Give \(\text{Yes} \)	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	lican, etc.)	Black, White, e	
ğ	ral', c	d by	3 ☐ Widowed 4 ☐ Xivorced If Yes, Give 12 Year or Dates:	1 ☐ Yes 2 HNo Specify:		Specify: Whi	te
7	tied within 72 hours after deeth with the Maryland Hygiene. uther than "natural", or iteme 23a or 28e-f ehow ont, It a Medical Examinar must be notillied at	Completed	15. Decedent's Education (Specify onfy highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g 16b.	Kind of Business/Indu	ustry
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2	be tiled within 72 hours after deeth with the Marylan tal Hygiene. d other than "natural", or iteme 23a or 28e-f show event, It a Medical Examinar must be notified at		12 17. Father's Name (First, Middle, Last)		(First, Middle, Maide		
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ary	should and Men s marke umatic	-		ing Address (Street and Number or Rural		or Town, State, Zip (Code)
Σ	s 1 and 2 should if Health and Men item 27 is marke other traumatic		Catherine Harich - Niece 2411	Braddock Road, Mc	ount Airy,	Maryland	21771
altimore, Maryland 21215-0036	m 0	. 8	20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		ocation - City or Tow	n, State
Ē	Pages tment of I tent; if it	1	`4 Depation 5 □Other (Specify) Providen	ce Cemetery 4/22	/06 K	emptown,	Maryland
Bal	permit. Page Department Importent; if any injury o			2. Name and Address of Facility Molesworth-Williams	P.A., Fu	neral Hom	e
	40240		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	26401 Ridge Road, I	Damascus,	Maryland	20872 Approximate
			shock, or heart failure. List only one cause on each line.		respiratory arrest,		Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death) a	cancer		1	porths
	Examiner		· ·				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury				-
	and trans	Examiner	that initiated events				
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):				
687	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai	d				
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	v
m.	death e atte	iciai	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)			Day Year
0.0	at the de by the a tached	hys	9 ☐ Unknown				
Ś	res that igned to be deta	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the	
ord	w require been significant	ted			1 Yes	2 □ No 3 ■ Preba	bly 4 □Unknown
ec	alaw hasb e 2 st	Completed			24a. Was an autopsy	prior to com	sy findings available pletion of cause of
ä					performed?	o death?	2□ No
=	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outoatie	26. Place of Death		- Cou 10 11	
ō	y Phye er this eral di	H-	27. Manner of Death 28a. Date of Injury 28b. Time		8d. Describe how inju		
<u>0</u>	Attending or death.	atio	1 (Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural	Route Number,
	itel or irs efte rei Dir lled in						
	To the Hospitei within 24 hours e To the Funerei I completely tilled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, all nvestigation, in my opinion, death occurre	nd due to the cause(d at the time, date ar	s) and manner as sta nd place, and due to	ited. the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	29c. License number D 26 4 99		ate signed (Month, Doril 20, 2	•
	0		30. Name and address of person who completed cause of death (Item 23a) (Type Ronald E. Miller M.D., 4 Culwell	Print) Drive, Mount Airy	_		
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 1 2005	food .			

		Sta State	te of Marylar		ent of Health and I	Mental Hy	giene	14081
		Registrar		Centrica	ate of Death	2. Date of Dea	Reg. No.	1 7 0 0 .
Physicia	_	1. Decedent's Name (First, Middle, Last)	rince	Bechte	. (d	APRIL	Day Year 19 2000	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street a			ty, Town, or Location of Deatl		4c. County of Dea	
		Washington Coun	ty Hosi	pital	Hageistown	-	WASH	ington
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.) Yrs. If Uni	der 1 Year If Under 24 Hrs. is Days Hours Min.	8. Date of Birt (Month, Da	h 9. Bii	thplace (State or Foreign ountry)
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yland		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
Mar B-f-h	ctor	PA Fulton		Merce	Spare			1 □ Yes a No
or 28	Director	10e. Street and Number	1 2		Zip Code 0		10g. Citizen of What C	•
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ter de	une	Am	s Decedent Ever in to ged Forces? Yes 2 □ No	I.S. 13. Was De	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
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21215-UU36 within 72 hours after death with the Marylar piene. rthen "natural", or iteme 23a or 28e-f ehow the Madical Examinational by molified at	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Decedent's U	sual Occupation work done during most of wor	rkina	16b. Kind of Business	
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W C		17. Father's Name (First, Middle, Last)			18 Mother's Nar	me (First Middle	Maiden Sumame)	•
ed fa b	To Be	William L.	Bechlo	101	1/	inia G	aldsberg	
and share	-	19a. Informant's Name/Relationship (Type, Prin	nt) .		ess (Street and Number of Ru		er, City or Town, State,	Zip Cqde)
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Saltimore bermit. Pages 1 i Depertment of He mportant: If iten my injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova		Place of Disposition (/ cemetery, crematory of		Date 20/06	20c. Location - City of	Town, State
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Baitim permit. Pag Depertment Important: eny injury o		21. Signature of Funeral Service Licensee			and Address of Facility Bradbury Ave		Davis Funei	
		23a. Part1. Enter the disease, or complications	that caused the dea					Approximate
Physician		shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.			. ,		Interval Between Onset and Death
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/ P = 5	Iner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a conser	quence of).	4			
and I-tran	Examiner	that initiated events c.	Due to (or as a consec	quence of):				
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit.	dlcalE		(, , , , , , , , , , , , , , , , , , ,	1 ,.				
587 tificate g phy as the	edic	U						
BOX 6 leath certific attending p	by Physician/Me	23b. Was decedent pregnant	es, outcome of pregn		pregnancy		23d. Date of de	,
he dea	sicia	1 Yes 2 No	Pregnant at time of o				Month	Day Year
ires that the de signed by the a	Phy	Part II. Other significant conditions contributing	on to death but not re-	sulting in the underlyin	n causa given in Part I	23e Did to	obacco use contribute t	o the cause of death?
dS, signe d be d		5/9 presmone	, ,	u- melen	-			robably 4 □Unknown
w require been sig	ete		-	<u> </u>		24a. Was	an 24h Were a	utonsy findings available
He far he far e has	ompleted					autop perfo	rmed? prior to death?	utopsy findings available completion of cause of
	ပ	25. Was case referred to medical	WITCH THE TOTAL	- 17	26. Place of Dea	1 Nes ath Check only o	2 No 1 No	s 2□ No
Of VI Physici this cer al direc	To B	examiner? 1 Ses 2 No Hospital	Inpatient 2	ER/Outpatient 3	Other		lence 6 □Other (Spe	ecity)
ng Ph Ing Ph After th Ineral		27. Manner of Death 1 Natural 5 ☐ Pending 28a.	Oate of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred	
ISIO Itendi Jeath Itor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	Diagonal Indiana Albania	M	1 Yes 2 No	206 Leastine /6	344	
DIVISION OF tel or Attending Phy s after death. el Director: After this ed in by the funeral d	Certification:	4 Homicide determined 286.	building, etc. (Speci	iome, farm, street, fac fy)	ory, office	City or Tow	Street and Number or R vn, State)	urai Houte Number,
DIVISION Of VITA Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician:	To the best of my kn	owledge, death occurr	ed at the time, date and place	, and due to the	cause(s) and manner a	s stated.
n 24 h	Medical	(Check only 2 Medical Examiner: Or one)	the basis of examination the examination that the basis of examination the examination that the examination that the examination that the examination that examination the examination that the examination that examination the examination that exa	ation and/or investigat	on, in my opinion, death occu	irred at the time,	date and place, and du	e to the cause(s)
To t To t comp	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mon	***
		Kl Ry la			1738764		4/21/06	
15		30. Name and address of reson who complete	d cause of death (Ite	m 23a) (Type, Print)	mps, Rd suit	. 123	1 4)	MD 2111A
Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	- Post 1- 2000	4 107	1.078-1000	. () - () (3)
Registr	100	MAY 0 3 200	Milione.	No Page				

			1 - State Registrar	State of Maryla	nd / Dep	artme			d Menta	al Hygie	-	16	408	82
	Physici	an	Decedent's Name (First, Middle, Last)	1					Mo	ite of Death	Day 14,	Year	3. Time of	
1 2 2	/Medio	al	Helen R. Bel			45 00	-		Apı	:11		2006	7:10) A.M.
	Examir	er	4a. Facility Name (If not institution, give s Manor Care	treet and number)		40. CI	Poto	Location of Deam	atn	:		ity of Death Ltgome1	r.v	
4	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday,		der 1 Year	If Under 24 H	Irs. 8. Da	te of Birth		9. Birthpl	lace (State o	or Foreign
	Director		577-12-7712 Usual Residence of Decedent	M 2 F 8.		Month	s Days	Hours Mi	Jur	te of Birth onth, Day, Y ne 12,	1920	Count	ginia	
	Marylan a-f ehow	tor	Maryland Montgomer		city, Town or Lockvill							10	0d. Inside C	City Limits 2 ☐ No
	h with the	ai Direc	10e. Street and Number 4517 Dabney Drive				Zip Code 20853			100		f What Count	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow enty Injuty grother traumatic event, Ite Mudical Examination to be invitted at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	If Yes, sp	cedent of H pecify Cuba No	ispanic Origin? In, Mexican, Put Specity:	(Specify Y erto Rican,	es or No- etc.)		ace - America lack, White, e hify: White	etc.	
215-0	hin 72 ho n. "natur Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							16	b. Kind of	Business/Ind	lustry	
2	giene giene	S m	Elementary/Secondary (0-12) 12 Years			Home	maker	•			Own	Home		
Maryland 21215-0036	uld be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) Sol Belkov					18. Mother's N		, <i>Middl</i> e, Ma nascer		,		
Mary	nd 2 sho sith and 1 27 is ma		19a. Informant's Name/Relationship (Type Max Beloff - Husl		19b. Mail 4517	ing Addre	ess (Street a	ond Number or P	Rural Rout Rockv	ille,	City or Tow Maryl	n, State, Zip and 2	Code) 20853	B
Baltimore,	ages 1 a ant of He nt: If Item		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □Re 4 □ Donation 5 □ Other (Specify)	44 00 1	Place of Disponentery, creens Davi	matory o	r other plac	lns 4/18	Date 3/2006			Church		rginia
Baltii	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service License		2	dwar	and Address	sel ^{Fag} iyne ville Pi	eral I	Direct	ion,	Inc.		20852
,092	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):		me v		nac on resp	iatory arres			Approximal Interval Bet Onset and	tween
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rds, P	quires that n signed b		Part II. Other significant conditions con		esulting in the t	underlying	g cause giv	en in Part I.	2	3e. Did toba 1		ntribute to th	ably 4 🗆	
al Records,	ding Physician: The law require h. After this certificate has been sit funeral director, page 2 should b	Completed							-	4a. Was an autopsy performs Yes 2		death?	osy findings npletion of c	
ĬŽ	ician certifi rector	Be	25. Was case referred to medical examiner?	ospital:			DOA Cth	26. Place of D						
ō	Phys this ral dii	5	1 Yes 2 No	1 ☐ Inpatient 2	☐ ER/Outpatie		DOA	4 A INCUISING		Residen		ther (Specify	"	
Division of Vital	lending leath. lor: After the fune	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	М		k? Yes 2 □ No						
Ω	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	treet, fact	ory, office		28f. Lo	ocation (Stre ity or Town,	et and Nur State)	nber or Rura	! Route Nuп	nber,
	To the Hospital or A within 24 hours after To the Funerel Directornoletely filled in by	edicai	29a. Certifier 1. Certifying Phys (Check only 2 ☐ Medical Examin	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurrenvestigati	ed at the tin on, in my o	ne, date and pla pinion, death oc	ace, and du ccurred at t	ie to the cau he time, dat	se(s) and a	manner as sta e, and due to	ated. the cause(:	s)
	To the To the comp	ž	29b. Signature and title of certifier				29c. Licens					ned (Month, I	Day, Year)	
	3						D 005	4566		4	1141	06		
			30. Name and address of person who con Sunitha Shogavile	i, 1220A &	est To	Ppo	Roa	d Sceo.	h 23	o, Jox	oson	, HD2	2128	6
	Sta Regist		31. Date filed (Month, Day, Year) APR 19 20	32. Registrar's Sig	nature	back	9							

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2006 16, а м Marv Frances Brennan April 8:30 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2210 Bucknell Terrace Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct. 9, 19 6 Sax 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 ☐ M 2 🖾 F Months Days Hours 52 Maryland 213-66-9141 1953 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: if Item 27 is marked other than "neturel" or Items 27 is marked other than "neturel" or Items 27 is marked other than "neturel". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2210 Bucknell Terrace 20902 USA Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 200 Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Manager Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jack Simpson Joan Ruth Hayes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Brennan, Jr./Husband 2210 Bucknell Terrace, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State April 22, Gate of Heaven Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis dogs Collins Funeral Home Inc. /Cobert Ekar 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clude on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Massive Brain Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Advanced Glioblastoma Multiforme burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? þ å Seizure Disorder 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed? certificete 20 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) P 1 ☐ Yes 2 ☐xNo 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural Injury death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e cai 29a Certifier t Centifying Physician: To the best of my knowledge, death oncurred at the time, date and blace, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the I within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60036 April 17, 2006 An 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmoud Doski, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year)
APR 19 32. Segistrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Anthony Wayne Collins

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		1- For State Registrar		Cert	ificate of Dea	ath		Reg	3. No. 201	16 14181
Physici	an/	1. Decedent's Name (First, Middle	,Last)					Date of Death Month	Day Year	3. Time of Death
Medical Exami	iner	Anthony	Wayne		Collins		^	pril 23, 20	006	2124 hrs
		4a. Facility Name (if not institution East Bound Fox Borne	_			, Town, or Location of 7 & Fox Burrow			4c. County of E	Death
Funeral		,		e (In yrs. las	t birthday) If Ur Mor		1.00		T _E	9. Birthplace (State or DC
Director		577-82-5198	1XXM 2 F	42	Yrs.	ths Days Hours	S IVIIII.	Jan. 14	, 1964	CountWashington
8		Usual Residence of Decedent 10a, State 10b, County		10- 01 T						Land to the Oa Live
w any				-	own or Location					10d. Inside City Limits 1 Yes 2XXXNo
/land -f sho	ģ		y S	Media	micsville			1.0		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 26643 Cecile Court			10t. 2	tip Code 20659		109	g. Citizen of What USA	Country?
n with	eral	11. Marital Status	12. Was Decedent Armed Forces?			dent of Hispanic Orig			14. Race - A White, e	American Indian, Black,
ter death ", or ite er must	Fun	1 Never Married 2 Mar 3 Widowed 4 XX Divo	1 Yes 2	XX No		2xx No specify		an, etc.)	Specify:	White
rurs af rtnral amin	d by	15. Decedent's Education (Speci	or Dates:	pleted) 1	I6a. Decedent's Usu	al Occupation (Give	kind of work		16b. Kind of Busin	ness/Industry
72 ho n "na al Ex	ete	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	_	orking life. DO NOT	,		α.	
5-0036 led within 72 hours at Hygiene other than "natural the Medical Examin	Completed	12			Foreman / H					cruction
ID 21215-0036 should be filed within 7 and Mental Hygiene ?7 is marked other than natic event, the Medica	Be Co	17. Father's Name (First, Middle, I Herbert Wayne				18.Mother Donr	's Name (Fir na Mari c	st, Middle, Ma e King	aiden Surname)	
y, MD 2121 and 2 should be fi lealth and Mental. tem 27 is marked traumatic event.	To B	19a, Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing Addre	ss (Street and Nun	nber or Rura	Route Numb	er. City or Town.	State, Zip Code)
MD Should 2 should hand ma 27 is aumattic		Herbert W. Collins			1	ickson Avenu				
e, M I and 2 Health Item 2	•	20a. Method of Disposition			ace of Disposition (N	ame of cemetery,			20c. Location - Ci	
= 25 32 = 51		1 XXBurial 2 Cremation 4 Donation 5 Other Spe		Ft.	ematory or other place Lincoln Cem	etery	04/28/	2006	Bladensbur	rg, Maryland
Baltimo permit. Page Department of Important: injury or ott		21. Sig / ure of Pineral Service L	icensee		22. Name ar	nd Address of Facility	George	e P. Kal	as Funeral	. Home PA
@ 80 5 5 5	9.9	121:19-			6160 (Oxon Hill Ro	oad Oxo	n Hill,	Maryland	20745
Physician Medi-		23a. Part I. Enter the disease, or of failure. List only one cause of		the death. [o not enter the mod	e of dying, such as c	ardiac or res	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and
cxaminer	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries							Death
40a			Due to (or as a conse	equence of):						
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e exection a	n/Medical	UNPENDED	AMENDED							
68760, certificate be ading physic se as the bur	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna					23d. Date of de	livery
Sox 687 leath certific e attending for use as t	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	time of deat	2 Fetal deat		pregnancy		Month	Day Year
Box e death c the atten	Physicia	1 Yes 2 No 9 Unkr	, L		n 5 Other (Sp	pecify)				
O. B at the de 1 by the tached 1		Part II. Other significant condition	ons contributing to death	but not res	ulting in the underlyi	ng cause given in Pa	art I.	23e. Did tob	acco use contribu	te to the cause of death?
P.C. res tha signed be det	d by							1 Yes	2 🗸 No 3	Probably 4 Unknown
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e law e has ge 2 s	Completed							autopsy perform	ned? dea	th?
tal Rection: The certificate		25 Was case referred to medical				26.Place of Death	(Check only	1 Yes 2	No 1 ✓	Yes 2 No
Vital Rec ssician: The his certificate	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient 3	DOA Other	Nursing Ho		tesidence 6 🗸	Other: Scene
Division of Vital Records, P.O. tal or attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	2	27. Manner of Death	28a. Date of Inju	ry 2	28b. Time of Injury	28c. Injury at Work			w injury occurred	
ion tendir eath. or: A	흹	1 Natural 5 Pendi 2 ✓ Accident Invest			FOUND: 2131 hrs	1 Yes 2		ceased dri uck-tree	iver of motorc	yclethat left road,
ViSi or Att fter de in by	j <u>ë</u>		igation		ne, farm, street, facto	ry, office building, et	c. 28f			or Rural Route Number, City
pital of pit	Certification:	4 Homicide determ	nined (Specify) Loc	al Street			J-22	or Town, Sta 27 @ East	Fox Burrow F	Place, , MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical (ysician: To the best of my niner:On the basis of exam							
To the within To the compl	Med	29b. Signature and title of gertifier	and manner stated	7/1		9c. License number			· · · · · · · · · · · · · · · · · · ·	(Month, Day, Year)
		XM///dl	1/	1		O.C.M.E.		- 1	April 24, 2006	
d		30 Name and address of person v	who complete cause of d	eath (Item ?	3a)				. = -, ===	
8	J. J		ssistant Medical Ex			eet, Baltimore, N	MD 21201	1		
S	tate	31. Date filed (Month, Day War)	A 5	's Signature	6.	2				
Regis		mrt 0	0 2000	Charles and	- 1-h-	2				

			1 - For State Registrar	State of M	arylan		artmen rtificat			ınd M	lental H	ygien Reg. N		6	and the same of th	85
12	Di-		Decedent's Name (First, Middle, La	st)							2. Date of E		ay	Year	3. Time	of Death
	Physic /Medi			Tony		Caruso					April				2033	В Р ^м
	Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City,	Town, or	Location of	f Death		4	c. County	of Death	1	
			Prince Georges	Hospital			Ch€	everl	Ly			P:	rince	e Geo	orges	
18.	Funeral		5. Social Security Number 6. S	Sex 7. Ag IOXM 2□F	ө (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B		r)	9. Birth	place (State	or Foreign
4.	Director		5//-14-/159	12 M 2 L F	90	Yrs.		Suyo			Nov.		915	Wasl		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation								10d Inside	Circlinia
	eho	5	MD. Prince (Ceorges	700.01		attsv	7:110							10d. Inside	es 2 No
	he M	Director	10e. Street and Number		<u></u>				> 							
	72 hours after death with the Maryland naturel, or items 23a or 28a-f ehow disal Examiner must be notified at	ō		~			10f. Zip		20704			10g. C	itizen of V	What Cou	intry?	
	s 23	Funeral	3707 Warner Ave						20784				USA			
	er de litem	une	11. Marital Status	12. Was Decedent Armed Forces		.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cubai	spanic Orig n, Mexican,	jin? (Spe , Puerto f	cify Yes or N Rican, etc.)	10-		e - Amer ck, White	ican Indian, , etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates:	NO		1 □ Yes	No	Specify:				Specify	: Wh	ite	
8	hou	edt	15. Decedent's E			16a. Dece	dent's Heur	al Occupa	tion			165	Cod of D			
5	in 72	Completed	(Specify only highest gra			(Give	kind of wor DO NOT us	rk done d	furing most	of workir	ng	100.1	Kind of Bu	usiness/ii	ndustry	
12	within ene. than "	mc	Elementary/Secondary (0-12)	College (1-4or	5+)	_	rist	, , , , , , , , , , , , , , , , , , , ,				Flo	oral			
Maryland 21215-0036	be filed within 72 hours after death with the Marylan stal Hygiene. Id other than "naturel", or items 23s or 28s-f show other than "naturel", or items 23s or 28s-f show ent, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last,)					18. Mother	's Name	(First, Middl			10)		
an		To Be		Filippo (amie.	0					stina			/		
<u> </u>	d 2 should be the and Menta the and Menta T is marked traumatic even	F	19a. Informant's Name/Relationship (ar us		ng Address	(Street a	nd Number		Route Num			State 7i	n Code)	
Ma			Corinne Fuller -			1									p code/	
ē,	ss 1 and 2 of Health litem 27 i		20a. Method of Disposition	daugittei	20b. P	lace of Dispo	sition (Nan	ne of			Mary				own, State	
0 D	Pages nent of int: If it		1 Burial 2 Cremation 3			emetery, crer			1 11.	4-22	-06			•		~ i ~
Baltimore,	보본 문급 .	1	4 □Donation 5 □ Other (Specification 21. Signatur) of Funeral Service Licer		Mec	ropoli			s of Facility			2010			Virgi	IIId
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rds, P.	The law requires that ate has been signed b bage 2 should be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the ur	nderlying ca	ause give	n in Part I.			tobacco Yes 2	_	ribute to t 3 □ Prot	he cause of	death? JUnknown
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						26. Place o	of Death	(Check only	one)				
$\stackrel{\leftarrow}{=}$	hysi his c	၉	1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆	ER/Outpatien	t 3□ DO	A Othe	r. 4 🗆 Nurs	sing Horr	ne 5 🗆 Res	idence	6 □Othe	er (Speci	fy)	
0	ng P. Iter t nera		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	8d. Describe	how inju	ry occurre	ed		
<u>Ö</u>	auth. or: A	atle	2 Accident investigation			,	М		es 2 N	0						
Divis	To the Hospital or Attending Physicien: within 24 hours after deals as flet deals To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	building, et	c. (Specify	·)					8f. Location City or To	own, State	θ)			mber,
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44	* 3		30. Name and address of person who			23a) (Type, I	Print)		,	1						
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			For State Registrer	State of	Maryland		artment o			nd Me		iene	06	140	86
			Decedent's Name (First, Middle, I	Last)							2. Date of Dea			3. Time of	Death
	Physicia /Medic	al	Jerry Calhoun 4a. Facility Name (If not institution, g	nive street and numb	oer)		4b. City, Tow	m, or Lo	ocation of D	Death	Month 04	18 4c. Cou	Year 06 nty of Death	6:45	A M
	Examin	C.					Camp					Pri	rce Ge	eorges	
	Funeral		6802 WestChester 5. Social Security Number 6		. Age (In yrs. Ia	ast birthday)	If Under 1 Y	ear If	f Under 24	Hrs.	8. Date of Birth (Month, Day			place (State ointry)	or Foreign
	Director		420-68-9451 Usual Residence of Decedent	1X M 2□ F	_58	Yrs.	Months Da	ays I	Hours		02 - 09-4		002	AL	
	and and		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
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	r 28a	Director	10e. Street and Number	Georges			10f. Zip Cod	de			1	0g. Citizen	of What Cou	intry?	
	h with		6802 WestChester	Drive			201	748				Unit	ed Sta	ates	
	ems a	Funeral	11. Marital Status	12. Was Deced Armed Ford		5. 13.	Was Decedent	of Hispa Cuban, I	anic Origin Mexican, F	? (Spec	cify Yes or No- Rican, etc.)	14. F	Race - Amer Black, White		
36	72 hours after death with the Maryland naturel', or Items 23s or 28s-f ehow Jisal Exatrición unit be notified a	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 N Yes 2 If Yes, Give	:□No es:3-69-		1⊡Yes 2⊠		Specify:				cify: Bla	ck	
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yla	should be and Mental marked o	၉	James Calhoun								orden				
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Baltimore,	Pages nent of H ant: If its ury or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		lale		natory or other cion Ce		277 t O	1-21	2-06	Clinto	n MD		
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Il Records,	The ate h page	Completed	Diabetes								24a. Was a autop perior 1 Yes	med?	prior to death?	topsy findings ompletion of 2 \(\text{No} \)	available cause of
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Division	l or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - At ho g, etc. (Specify	ome, farm, st	reet, factory, of	fice		2	28f. Location (S City or Tow	itreet and Nu n, State)	ımber or Ru	ral Route Nur	mber,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier X Certifying (Check only one)	Physicien: To the tax xaminer: On the bar and mann	sis of examinat	wledge, deat	th occurred at to	he time, my opin	, date and nion, death	place, a	and due to the dead at the time, d	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Xalk	MI		29c. Li	icense n	number 36 S	50.	5		ned <i>(Month</i>	, Day, Year) 2006	
2	(12)		30. Name and address of person w Eunice Shakir,	to completed cause M.D., 610	of death (from	23a) (Type Branch	Print) Avenue				ngs, MD	20748	3		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR: 2 0 20	06 £2. Re	egistrar's Signa	ture	le								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 06 **Physician** 16 14:40M DORENE CARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S FT. WASHINGTON FT. WASHINGTON HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 3-21-1941 9. Birthplace (State or Abreigh 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months ATLANTIC CITY 65 149-30-7379 Yrs. Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f ehow Examiner must be notified at 1 XYes 2 No Directo PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1215 FARMINGDALE AVE., 20743 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturei" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Department of Health and Mennat Hygiene. Important: if item 27 ie marked other than "n. eny injury or other traumatic event, the Medical. College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC DOMESTIC 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TURNER CHARLES CARY ral Route Number, City or Town, State, Zip Code) 20743 DR. CAPITOL HEIGHTS, MD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 N. ENGLEWOOD DENISE FAGINS/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MD HARMONY MEM. CEM. 4-21-06 4 ☐ Donation 5 ☐ Other (Specify) CAPITOL MORTUARY 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility 1425 MARYLAND AVE., N.E. WDC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Candiovarda Niscare theroschen tic **Physician** /Medical Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires thet the death certificate be executed attending physiclen and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 2No detached å 9□ Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 1 Tes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 Mo 2 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 Tes 2 No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier

DHMH 17 Rev 1/2001

State

Registrar

MSidnoh) (0 31. Date filed (Month, Day, Year)

APR 2 0 2006

worksta Mo 207(6)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	· \		1 - For AMEND#5 per fin State Registrar AACO HEALTH	DEPT. OH	arylan	d / Depa	artment rtificate	of H	ealth a	and M		Heg. No.	06	140	88
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	/Medi	cal	Mary 4a. Facility Name (If not institution, g						Location o		April		2006 nty of Death	5:22	_a ™
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	Funeral			Sex 7. Ag		ast birthday)			If Under:	24 Hrs.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State ontry)	or Foreign
ė,	Director			1 □ M 2 XX	68	Yrs.	IVIOITATIO	Days	110013		April	10,1938	Mar	yĺand	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation		-					10d. Inside C	ity Limits
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-	r 28a	Funeral Director	10e. Street and Number		10.	LVG	10f. Zip	Code				10g. Citizen o	of What Cou	intry?	
	23a o	alD	403 Circle Road					2114	00			Ţ	ISA		
4	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13.	Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.))- 14. P	ace - Amer lack, White		
36	s afte	by F	1 Never Married 2 Married 2XXWidowed 4 Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No		1 ☐ Yes	XX No	Specify:			Spe	cify: W	hite	
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<u> </u>	2 should be 1 and Mental 1 ie marked o aumatic eve	To	William Irvin No			105 14-22		(C1-1-1-1			oreland		um Ctoto 7	in Code)	
Mar	~ C ~ =		19a. Informant's Name/Relationship Euna Obremski (MD 21		m, State, Zi	, Code)	
	Pages 1 and 2 should nent of Health and Mer ant: If item 27 ie marke ury or other traumatic		20a. Method of Disposition	JISCEL)	20b. P	lace of Dispe	osition (Nan	ne of			ate 2.1.	20c. Locatio	n - City or T	own, State	
Baltimore,			1 N Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		1	emetery cre Linc	-			/ı10	-2006	Brent	trood.	MD	
	리틴론들 .		21. Signature of Fineral Service Lic		TU		2. Name an	d Addres	s of Facilit	ty			woou	FID	
ä	Depa Impo any l		Date 2	MI			Harde 12 R	esty idge	Fune 1v Av	ral enue	Home, l , Anna	P.A. polis.	MD 21	401	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 2006 Lillian C. Cagle April 20 12:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Continuum Care Sykesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours North Carolina 1 □ M 2 🕱 F Yrs Nov 20, 1917 Director 88 246 32 0727 Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "natural", or items 23s or 28s-f show other treumetic event, the Medical Evantural must be rotified at 1 ☐ Yes 2 X No MD Marriottsville Howard Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12510 Old Frederick Road 21104 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Infroortant: If item 27 is marked other then "na arry injury or other treumetic even" Elementary/Secondary (0-12) College (1-4or 5+) 9 Packer Aluminum 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Brown Nettie Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12510 Old Frederick Rd Marriottsville, MD 21104 Floyd N. Cagle/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Cemetery 4-22-2006 Baltimore, MD M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final **Physician** ans disease or condition resulting in death) /Medical **Examiner** 250 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: Nursing Home To 3□ DOA 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After t or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 0 2 Tootom of death (Item 23a) (Type Ó 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

		_	For State Registrar	State of Ma	•	epartment o Se <i>rtificate d</i>	f Health and I of Death		giene Reg. No.	106	14091
	Physici	an	Decedent's Name (First, Middle Georgia	, Last)	Caperon	108		2. Date of De Month April	Day	Year	3. Time of Death 3:05a
	/Medic		4a. Facility Name (If not institution	. give street and number)	Caperor		m, or Location of Death			ounty of Death	
	Examin	er	Suburban Hos			-	thesda		м	lontgom	erv
	Funeral Director		5. Social Security Number	-	88 Yr	day) If Under 1 Y		8. Date of Bir (Month, Da May 17	th ly, Year)	9. Birth	place (State or Foreign intry) Bece
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	e Ma	Director	Maryland Mont	gomery	Kens	ington					1 ☐ Yes ≩
	th th	Oire	10e. Street and Number			10f. Zip Co	de		10g. Citize	n of What Cou	intry?
	23a		4308 Dresdan St				0895			USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be multiled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify 1 Yes 2	of Hispanic Origin? (S Cuban, Mexican, Puerl No Specity:	pecify Yes or No o Rican, etc.)		. Race - Ameri Black, White	, etc.
Maryland 21215-0036	in 72 ho "natur	Completed	15. Decedent (Specify only highes	st grade completed)		ecedent's Usual O Give kind of work d ife. DO NOT use re	one during most of wor	rking	16b. Kind	of Business/Ir	ndustry
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au	id be ental ked c	To B	Christos Ch	ipouras			Pauline	e Coliv	es		
2	Shound M mari	-	19a. Informant's Name/Relations		19b. N	Mailing Address (St	reet and Number or Ru	ıral Route Numb	er, City or T	own, State, Z	p Code)
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ā,	Hea Hea tem	1	William Caperon 20a. Method of Disposition	les_f. nusbauc	20b. Place of D	Disposition (Name of crematory or other	an Street l	Date	20c. Loca	ition - City or T	own, State
<u></u>	age untof		1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		1	od Cemet	1	0/2006	Wash	ington	n c
Baltimore,	ortan Injury		21. Signature of Funeral Service		GIEHWC		ddress of Facility Hi 1				
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			23a Part 1. Enter the disease, or shock, of heart failure. List	complications that caused only one cause on each li	the death. Do no	t enter the mode of	dying, such as cardia	or respiratory a	ırrest,		Approximate Interval Between
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1	/Medical		resulting in death)	Due to (or as	a consequence of):					
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oʻ	an ar rial-t	EX	resulting in death) Last	Due to (or as	a consequence of):					
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_	tifica ng ph as th		The services								
P.O. Box	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □ Ectopic pregr 5 □ Other (specif			23	d. Date of deli Month	very Day Year
	that led b deta		Part II. Other significant condition	ons contributing to death b	ut not resulting in t	he underlying caus	e given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ds	uires sign ld be	d by	Renal Failure					1 🗆	Yes 2□	No 3□ Pro	bably 4 X]Unknown
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Ž	ling I I. After uner	<u>o</u>	1 Natural 5 ☐ Pendin	ig (Month, Da		ury M	Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe	now inquiry	Scalled	
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Division of Vital Records,	or A after of Direction by	Certification;	4 ☐ Homicide determ	building, et		n, street, factory, of	lice		wn, State)	TOMOGRAPH OF THE	al Flocio Wallion,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifyir (Check only 2 ☐ Medical	ng Physician: To the best Examiner: On the basis o	of my knowledge,	death occurred at t	he time, date and place	e, and due to the	cause(s) a	nd manner as	stated.
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifie	and manner sta			cense number			signed (Month	
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	D		30. Name and address of person			ype, Print)			-		
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CAPERINES

			For State Registrar	ease				d / Depa		t of H	ealth a	and M		Reg. No.	006		1:09	2
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	/Medic	al	4a. Facility Name (If not instit	ution, giv					4b. City,	Town, or	Location	of Death	pr zz		County of D		. J u	
	LAGITIII		Woodside (Spr				ontgo		<u> </u>	
	Funeral Director		5. Social Security Number 213-21-4001		ex □M 2⊠F		e (In yrs. i 80	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day Mar	O', 1	926	Birthplace Country) ROM	(State or F ania	-oreign
	/land		Usual Residence of Deceder 10a. State 10b. Co	unty				y, Town or Lo								i	Inside City	
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	within 72 hours after death with the Maryland one. than "natural", or Items 28a or 28a-f show he Madical Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐	Married	12. Was Dec Armed F 1 ☐ Yes	orces?				22			ecity Yes or No- Rican, etc.)			/hite, etc.		
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ore,	if item		20a. Method of Disposition 1 ⊠Burial 2 □ Crema			n State		lace of Disponentery, creation					oate		cation - City			inia
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	Examir		4a. Facility Name (If not institution,	give street and n	umber)		4b. Cîty, Town, o	r Location o	of Death		4c. County	of Death	
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	Funeral			6.Sex 1⊠M 2□F		. last birthday)	If Under 1 Year Months Days	If Under :	Min.	 Date of Birth (Month, Day, 		9. Birth	place (State or Foreign ntry)
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6	* A		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
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S	mari mati	2	John Daugh 19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street	and Numbe				State Zir	Code)
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	penint. Tagge I land. Should be filled whiling to house and beauth with the wayran beauthent of Health and Mental Hybine. Important: If itam 27 is marked othar than "natural", or items 23a or 28a-f show any injury or othar traumatic evant, it a Modical Examiner must be notified at 90ce.		21. Signature of Funeral Service	Icensee /		22	. Name and Addres	ss of Facility	y Can	ital Ma	rtuary	Tno	,
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ğ	atter I for u	clar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	birth 2 ☐ Fet mant at time of	al death 3	Ectopic pregnancy Other (specify)				Mon		Day Year
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DIVISION Of the Most of the Afterday	within 24 hours after deat To the Funeral Director: Completely filled in by the	Med	29b. Signature and title of certifier	anu ma	nner stated.		29c. License	number		29	d. Date signed	(Month.	Day, Year)
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1	(2)		3. Name and address of person w	no completed car	ise of death (Ite	m 23a) (Type	Print)		- 2		11176	. (2	1000
V	6		Aut + NEV	WIZE M	142		renst	200	20	March	21501	6	2006
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	۵.	1					
	Registr	ar	APR 2 0 20	06	IN S	Andre	V						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 7:20 A M Hilda P. Dudyk April 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 932 Perry Landing Court Annapolis
If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 1 F Yrs. 100 Director 214-12-7546 Washington, D.C Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Mexical Examination at the notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 932 Perry Landing Court 21401 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 ie marked other than "natural", or ite ury or other traumatic event, It a Mexical Examics. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telephone 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lillian Violet Taylor James Walter Pumphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Dent/Daughter 446 Narrows Point Drive Grasonville, MD. 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Arlington National Cem. 4-26-06 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Maryland 21037 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR DISEASE 5 4 CARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? TO THRIVE certificate 2 □ No FAILURK 1 ☐ Yes 2 No 1 Yes the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending n 24 hours after death.

• Funeral Director: After the filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiers MOMPH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IIL DEFENSE HWY MARY 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registra

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) April 8, 2006 Physician William Hamilton Danneberg, Jr. 02:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5830 Beach Road Rock Hall Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AP KITT. Day Year 940 Birthplace (State or Foreign Country)
 MT 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 65 1 XM 2 ☐ F MD 168-32-0312 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Examinational be notified at 1 XYes 2 No MD KENT ROCK HALL Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21661 5830 BEACH ROAD 23a death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No ٥, Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) then. Flementary/Secondary (0-12) College (1-4or 5+) VICE PRESIDENT OF PUBLIC AFRS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If item 27 is marked oth eny injury or other treumatic event once. Be ANNE BONWILL WILLIAM H. DANNEBERG, SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5830 BEACH ROAD, ROCK HALL, MD 21661 LOUISE DANNEBERG/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State STILL POND CEMETERY 04/13/2006 STILL POND, MD * 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. P.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CROHN /Medical **Examiner** ATHOROSCUROTIC CHRONASCULAR MASOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transif physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medlcal use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 Yes 2 XNo or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Yes 2 🗌 No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titlerof certific 0005750 4/10/06 MEDICAL BRAMINES DEPUTE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESTESTIONNI MP WASHIN GTON AVE 31. Date filed (Month, Day, Year) 32. Registres Signature State APR 1 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Day Year **Physician** 28, 2006 April 5:30 A.M. Mary Joan Doyle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Emmitsburg Frederick St. Vincent Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□ M 2√2 F Yrs. 9, 1919 86 Pennsylvania Director 219-54-0308 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylend Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director Frederick Emmitsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21727 335 South Seton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1☑ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: À 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Religious Community College (1-4or 5+) College 5+ Elementary/Secondary (0-12) Daughters of Charity Retired TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Fleming John Doyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 333 S. Seton Avenue, Emmitsburg, MD <u>Sister Camilla Harant</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State EMMITSBURG, MD. 21727 ST. JOSEPH'S P.H. 5/1/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 Approximate Interval Between Onset end Death 23a. Part it finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical week Examiner Physician/Medical Examine ettending physiclan end I for use es the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 □ Yas 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital Records, P.O. Box 68760, After this certificate has funeral director, page 2 or Attending Physician: To the Hospital or Attendin within 24 hours efter death.
To the Funeral Director: At completely filled in by the fu

Certification: To edicai

1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident

29a. Certifier

5 ☐ Pending investigation 6 Could not be determined 3 Suicide 4 ☐ Homicide

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number 140044057 29d. Date signed (Month, Day, Year)

d ceuse of death (Item 23a) (Type, Print) PORT

DHMH 16 Rev 6/95

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 9:30 A M William Thomas Dohme, Sr. 18 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9324 Cropper Island Rd. Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 ☐ F Yrs. 72 Director 213-30-7951 8/30/1933 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. cither then "neturel", or items 23e or 28e-f ehow vent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9324 Cropper Island Rd. 21811 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: þ 3 ☐ Widowed 4 💆 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie marked of Ralph Dohme Regina Curran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Heelth ar Importent: If Item 27 is eny injury or other trau soce. Robert C. Dohme 6706 Mount Vista Rd., Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Park 4/25/2006 4 Donation 5 Other (Specify) Marritosville, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 234. Part 1. Enter the disease, or complications that cause it shock, or head failure. List only one cause on each line Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician ASCVO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? certificate has l 2 No 1 Yes : After this certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturat 2 Accident s etter des rat Diractor: Afte hv the fv 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerat D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, HUOJ371

Registrar

State

uto 302

30. Name and a ress of erson who complete cause of death (Item 23a) (Type, Print)

314 Franklin

32. Refistrar's Signature

MATRON E DO

APR 2 0 2006

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	aryland		ırtmen tificat			nd Mer		jiene og. No.	06		8
			Decedent's Name (First, Middle, Last)							2.	Date of Dea Month	th Day	Year	3. Time of D	Death
	Physicia /Medic		Esthe	er Fortun	ato d	le Pre	sta			A	pril 1	4, 20	006	2:47A	М
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			Doctors Community				Lanh		If Under 24	Hre o	Date of Dist		ice Geo		Famian
	Funeral		5. Social Security Number 6. Sex 115-63-0603	M 25₹F 82	e (In yrs. la:	st birthday) Yrs.	If Under Months	Days			Date of Birth (Month, Day UG.	1923	Arge	hplace (Stete or untry) entina	roreign
	Director		Usual Residence of Decedent	Λ 02							g. 17		1		
	land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City	
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	or 282	lrec	10e. Street and Number				10f. Zip				1		of What Co	untry?	
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	Funeral Director	5910 Natasha Drive					740				rgen		Taxanta da	
	r dea	ne	11. Warnar Claids	2. Was Decedent Armed Forces?		i. 13. V	Was Dece f Yes, spe	dent of His cify Cubar	spanic Origin n, Mexican, P	n? (Specify Puerto Ric	y Yes or No- an, etc.)	14.	Race - Ame Black, White		
30	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 I If Yes, Give Year or Dates:	No	1	1 X Yes	2 🗆 No	Specify:	Arge	ntinia	n s	pecify: Hi	ispanic	
3	filed within 72 hours after death with the Marylan Hygiene. Hygiene. Hygiene then "natural", or Itams 23a or 28a-f show after than "natural" as and the notified at ent. It is Modeal Examiner must be notified at		15. Decedent's Educ			16a. Deced	dent's Usu	al Occupa	ation			16b. Kind	of Business/	Industry	
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Maryland	should be f and Mental h s marked of umatic even	<u>م</u>	Jose Fortunato								enza (
a	(/ 00		19a. Informant's Name/Relationship (Typ						and Number o Drive						
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o o	it of F it its or ot		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	Ce.	metery, cren lcres	natory or o	ther place		/17/0	6		olis,		
Baltimore,	it. Parturent		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	4	1111				- ; .	•				1 Home	
Ba	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tone.		Ja 8 Naluh											d. 21037	7
			232 Part1. Enter the disease, or complic	cations that caused	d the death.									Approximate Interval Betw)
	Physician		shock, or heart failure. List only on Immediate Cause (Final											Onset and D	
	/Medical		disease or condition resulting in death)	Arrythn Due to (or as		ence of):					-				
8	Examiner		Composinity list conditions	Hyperte	ension	1									
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):									
	and -trans	Examiner	that initiated events c	Diabete Due to (or as		ence of):									
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∞ .	physics the	Physician/Medical													
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\mathbf{m}	death a atter d for u	Iclar	in the past 12 months?	1 Live birth 4 Pregnant a			∃Ectopic p ∃ Other (s						Month	Day Y	'ear
o.	that the de led by the a detached t	hys	9 🗆 Unknown	9Ll Unknown								-			
S,	res tha igned be de	by P	Part II. Other significant conditions con	tributing to death t	but not resu	itting in the u	nderlying (cause give	en in Part I.					o the cause of de	eath? Inknown
ord	w require been si should I										10,	/es 2□	NO 3 P	robably 4 V	Michigan
Records,	has be	Completed	·								24a. Was autop	SV /	24b. Were at prior to death?	utopsy findings a completion of ca	available ause of
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	4/	/		Oth	or:		Check only o		701 (0)		_
of	d is	. To	1 Yes 2 No	28a. Date of Inju	ury	ER/Outpatier 28b. Time o		OA 28c. Injun Wor	4 🗀 Nurs		d. Describe I		Other (Spe	ecity)	
on	ding h. After funer	ton	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ay Yeer)	Injury	м		k? Yes 2 ∏ No	0					
Division of	l or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of In			reet, factor	y, office		28	f. Location (Number or R	ural Route Numi	ber,
Ö	s after of Dire	Certification:	4 Homicide	building, e	itc. (Specify	/					J., 0, 701	, 91010/			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best	t of my know of examinat	wledge, deat	h occurred	at the tin	ne, date and pinion, death	place, and	d due to the Lat the time.	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
	the H hin 24 the F nplete	Medi	one)	and manner s					e number					th, Day, Year)	
1	To the within To the	~	29b. Signature and title of certifier	1.				MD60!				4/14	-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			30. Name and address if person who co	moleted cause of	death /Item	23a) /Tupo	Print)								
				118 Good				n,MD.	20706	6					
装	୍ର St	ate	31. Date filed (Month, Day, Year)		trar's Signat	ture	0								
	Regist		APR 1 7 20	06	er 1	7 4	and the	P							

State of Maryland / Department of Health and Mental Hygiene 4099 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 11:30P M Maria E. 15, 2006 Estrada April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F 633-70-6427 51 Nov. 19, 1954 Guatemala Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location r 28a-f show 10a State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Germantown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with 1 Department of Heelih and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23s or 2 any 1 urg or other freumatic event, the Medical Examinational being one. 21124 Tulip Poplar Way 20876 Guatemala Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned red 415/06 at 11:30 MB Baltimore, Maryland 21215-0036 1 ☑ Yes 2□ No Specify: Guatemalan Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Israel Morales Elena Valdes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Israel Morales/ Brother 21124 Tulip Poplar Way, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 24, t ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Cementerio General de 4 ☐ Donation 5 ☐ Other (Specify) Chiquimula, Guatemala Chiquimula Promed 22 Name and Address of Faculty Spring Funeral Home Inc.
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funerel Service Licensee nu 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weeks IVEY Physician allure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner acute leukenno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine muelodusplastic The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 ettending physicien Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Year Month Day 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ caucer 1 🗆 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification funeral director, it Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending s efter dean.
•• Director: Aftr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours at To the Funeral D completely filled i Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 5123 16,2006 2 who completed cause of death (Item 23a) (Type, Print)
Eas, M.D. 11520 Old Georgetown Road, Rockville, MD 20852 30. Name and address of person Pushkas, 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State 9 2006 Mary Mary Registrar

DO000

		1	State Registrar	State of Ma	aryland /		artment rtificate					Reg. No.	06		4100
	Physici		Decedent's Name (First, Middle, Last)								Date of De Month	Day		ar	3. Time of Death
	/Medic	al	Florence	<u>V.</u>	Fe1	ler:			1		April	18		006	10:58 A ^M
	Examin	er	4a. Facility Name (If not institution, give s		1				Location o	or Death			County of (
			Frederick Memoria 5. Social Security Number 6. Sex		a⊥ e (In yrs. last b	irthday)	Fred If Under 1	Year	CK If Under :	24 Hrs. 8	Date of Bir	th	reder 9.		ace (State or Foreign
	Funeral Director			м 2X F	78	Yrs.	Months	Days	Hours	Min.	(Month, Da				ny) inia
	P .		Usual Residence of Decedent												
	arylar show	_	10a. State 10b. County	_	10c. City, To									10	d. Inside City Limits 1 Yes 2 No
	88-f	ecto	Maryland Frederic 10e. Street and Number	k	Monr	ovia	10f. Zip (Codo			1	10a Citiz	en of Wha	t Count	
	a or 2	Funeral Director		1 D 1			TOI. ZIP		770		İ	rog. Onz			.,,.
	leath ns 23	eral	11637 Fingerboar	2. Was Decedent	Ever in U.S.	13.	Was Decede		770 spanic Orig	gin? (Specif	y Yes or No)- 1	4. Race ·		
(0	r Iten	F	1 Never Married 2 Married	Armed Forces?	No		llYes, speci 1 □ Yes 2			i, Puerto Rio	an, etc.)		Black, \	Vhite, e	itc.
03	ral', c	l by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			IL Tes 2	ZXINO	Specify:			,	Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland ane than 'natural', or Items 23a or 28a-f show ha Madisal Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation com <i>pleted)</i>	16	a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa k done d	ation during most	t of working		16b. Kin	d of Busin	ess/Ind	ustry
121	within	du	Elementary/Secondary (0-12)	College (1-4or 5	5+)		omemak)			0	wn Ho	mo	
	filed Hygie Hygie other I		17. Father's Name (First, Middle, Last)			110	Jiiiemak	.e.i	18. Mothe	er's Name (/	First, Middle			me	
lan	ld be ental ked o	To Be	Ernest Fincham							Annie	Fraz	ier			
Maryland	should ind Men s marke umatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19	b. Maili	ng Address	(Street a					Town, Sta	te, Zip	^{Code)} 20882
	and 2 salth a n 27 ls		Charlotte M. Parso	ns – Daug	ghter	8216	Sene	ca '	View	Drive	. Gai	ther	sburg	. M	aryland
ore	of He of He if itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place cernet	of Dispo ery, crei	sition (Nam matory or oth	e of her plac	9)	Dat	ө	20c. Loc	ation - Cit	y or Tov	wn, State
Ĕ	Pages ment of tant: If it jury or o		' 4 □ Donation 5 □ Other (Specify)		Gate						1/06	Silv	er S	rin	g, Marylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: if item 27 Is marked other than "natural", or Items 23a or 28a-f show amount in items and the rotified at one. Other traumatic event, I'm Medical Examination must be rotified at one.		21. Signature of Filteral Service License	Villia	ins	Mo	leswo: 401 R	rth-	Will:	iams E	A.,	Funer Mar	al H	ome d 2	20872
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each lir	ne.						1	rrest,			Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	MYC	CART.	DI A	41	WI	MARC	cho	n				2 400R5
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):									
		<u>-</u>	Sequentially list conditions, if my lasting to immediate	. Due to (or as	a consequence	e of):								+	
16	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence	e of):									
8760,	icate be executed physician and s the burial-transit	lical	d											_	
Ö	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	9	IF FEMALE:	3c. If yes, outcome	of pregnancy								3d. Date o	f alalisas	
Вох	attend for us	Physician/M	in the past 12 menths?	1☐Live birth 4☐Pregnant at	2 Fetal dea		☐Ectopic pre☐ Other (spe					2	Month		Day Year
O.	t the d	ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown											
<u>α</u>	s that ned b e deta	by Pł	Part II. Other significent conditions con	tributing to death b	ut not resulting	in the u	nderlying ca	use give	en in Part I.		23e. Did	obacco us	e contribu	te to the	e cause of death?
rds	w requires that been signed b should be det	ed E									1 🔼	Yes 2]No 3[] Proba	ably 4 □Unknown
Records,	as as b	Completed									24a. Was		24b. Wei	e autop	osy findings available
R	The ate h page	Com									perfe	2 No	dea	th? Yes	
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?							of Death (Check only	one)			
of V	S S	ဥ	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatie					4 140		5 Res			Specify)
on c		lo :	27. Man of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time o Injury	M ZE	Bc. Injun Worl	yat k? Yes 2 🗀		d. Describe	now injury	occurred		
Division	Attending r death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	urv - At home.	farm, st			103 2		f. Location (Street and	Number	or Rural	Route Number,
Div	af or At s after d il Diract id in by	Certification:	4 Homicide determined		c. (Specify)	, 0.	.001, 1401017,	, 000			City or To				
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Phys	nicien: To the best ner: On the basis o and manner st	f examination a	ge, deat and/or in	h occurred a vestigation,	at the tin	ne, date an pinion, dea	nd place, an occurred	d due to the at the time,	cause(s) a date and	and manno place, and	er as sta due to	ated. the cause(s)
	To the vithin 2 To the complex	Me	29b. Signature and title of certifier	1 0			1		e number			29d. Date	signed (#	Aonth, E	Day, Year)
	5		Daved B. 17	arch	1	10.		350	765			Ар	ril 1	9,	2006
	(3)		30. Name and address of person who co David Harding, M.	D. 60	2 Cente	er S		, Mo	unt A	iry,	Mary1	and 2	1771		
• *		ite	31. Date filed (Month, Day Year) APR 2 1 2	006 32. Registr	rar's Signature	k ,	Sport	1							
E	Regist	ar	717 17 7 - 1				1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28, 2006 **Physician** 03:15 Emmett R. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year)

Apr. 30, 19 Harford Memorial Hospital Harford 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 212-28-8740 1930 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c, City, Town or Location 10a State other traumatic event, the Medical Examiner rust be notified at Harford Havre de Grace 1XIYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e 906 Woodhaven Court 21078 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Fleet Manager Heavy Equip. Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental h Robert Funk Mammie McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 906 Woodhaven Ct. Mildred Funk (Spouse) Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/1/06 R. A. Ferris & Co. West Chester, PA ^¹ 4 □ Donation 5 □ Other (Specify) ²Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that oaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a coll sequence of): Priysician heart failure years disease or condition resulting in death) /Medical **Examiner** atrial fibrillatum Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ischemic cardiomy upathy Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? chronic obstructive pulmonary 2. No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 ours after death To the Funeral Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

runk, Emmett

311

29a. Certifier

Medical

29b. Signature and title of certification

29c. License number 000048050 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 155. Parke St. # 400 Aberdeen MD 2000 ~ 3 Registrar's Signature

Registrar

		,	1 - For State Registrar	State	of Maryla	-	artmen rtificate			and M	-	giene Reg. No.	06	14102
	Physici /Medi	cal	1. Decedent's Name (First, Middle 1) 4e. Fecility Name (If not institution	For	rest		4h City	Town or	Location	of Dooth	2. Date of De. Month	Bay B4	Year OG unty of Death	3. Time of Death
	Examir Funeral	ner	Anne Ar 5. Social Security Number	unde,	7. Age (In yr	(a) Cfr. s. last birthday)	If Under Months	nna	If Under	is_	8. Date of Bin (Month, Da Sep. 24	An	ne A	Irundel place (State or Foreign ntry)
	Director		577–48–3279 Usuel Residence of Decedent	1 🗗 M 2 🗆		69 Yrs.		Days	nouis	IVIUI.	Sep. 2	4,1936	Wash	ington, DC
	e Marylar Ba-f show	ctor		e George		Bowie	ocation	01					1	0d. Inside City Limits 1 XYes 2 No
	3e or 2	I Dire	10e. Street and Number 15808 Perkins	Lane			10f. Zip	716				_	of What Cour ed Sta	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □XNever Married 2 □ Marr 3 □ Widowed 4 □ Divorced	ied 1 7	Decedent Ever in 1 Forces? es 2F No Give 2 or Dates:		Was Deced if Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	- 14. F	Race - Americ Black, White, ecity: Blac	ean Indian, etc.
21215-0036	id within 72 ho giene. er than "natur ir e Medical.	To Be Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12th	complet Colleg	ed) e (1-4or 5+)	(Give	dent's Usua kind of wol DO NOT us NOWN	al Occupa rk done d se retired,	ation furing most)	t of work	ing	Depar	f Business/Ind rtment ections	Of
Maryland	uld be file Mental Hy trked oth	To Be (17. Father's Name (First, Middle, Unknown	Last)							e (First, Middle, ttler	Maiden Sun	name)	
	and 2 sho salth and I n 27 Is me er traums		19a. Informant's Name/Relations Marcelle Forre	nip <i>(Type, Print)</i> est (Da	ughter)						1 Route Number 325 Roc			
Baltimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S			Place of Dispo cemetery, crea Howard	matory or of	ther place	ty Sc)ate 17/06		on - City or To ningtor	
Balti	permit. Page Department of Important: # any injury or ance.		21. Signature of Funeral Service	Licensee		27	Austii 3821 1	d Addres 1 Roy 14th	ster Stre	y Fun	eral Ho NW Wash	ome ningtor	י דער פ	20011
	Physician // Medical Examiner transit the private transit the private transit	dical Examiner	23a. Part1. Ent. the state, or shock, or earl flure. List Immediate ause (final disease of condition resulting in death) Satisfied by list and the state ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due	1 ^	ath. Do not ent Sole / ev equence of): Y + ev equence of):	er the mode	e of dying	, such as	cardiac d	or respiratory ar	rest, A		Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Li	outcome of preg /e birth 2 ☐ Fe egnant at time of nknown	tal death 3	Ectopic pro			-			Date of delive Month	ory Day Year
rds, P.	quires that in signed by uld be deta	5	Part II. Other significant condition	ns contributing t	o death but not re	esulting in the u	nderlying ca	ause give	n in Part I.			obacco use c		e cause of death?
Il Records,	stcian: The taw requir s certificate has been si lirector, page 2 should	Completed											prior to cor death?	psy findings available inpletion of cause of
of Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐Inpatient 2	☐ ER/Outpatien	at 3 🗆 DO	A Othe	-		n <i>(Check only o</i> me 5 ☐ Resid		Other (Specifi	
ion of	Jing After fune		27. Manner of Death 1. Natural 5 Pendin 2 Accident investig	g 28a. Da g (A	ate of Injury Month, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe h			7
É	ital or Attenders rs after deatl al Director: led in by the	Certification;	3 Suicide 6 Could determ	289. PI	ace of Injury - At uilding, etc. (Spec	home, farm, str cify)	eet, factory	, office			28f. Location (S City or Tow	Street and Nu vn. State)	mber or Rura	l Route Number,
	To the Hospital within 24 hours and to the Funeral I completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	Exeminer: On th	the best of my kr e basis of examin anner stated.	nation and/or im	vestigation.	in my on	inion deat	th occurr	ed at the time	date and place	e and due to	the cause(s)
)	To the To the Comple	Σ	29b. Signature and title of certifie	in GR	DI	epur	290.	License	number	95	4	29d. Date sig	ned (<i>Month</i> , l	Day, Year)
	7		30. Name and address of person	JON	es, m	em 23a) (Type,	Print) 695	-	Ime	erie	4 c	2103	35	
	Sta Registr		31. Date filed (Month, Day, Year)	9 2006	2. Registrar's Sign	nature	parti	1						

		State State Registrar	ite of Maryland	-	rtment of H			jiene _{eg. No.} 0	06		03
Physicia		1. Decedent's Name (First, Middle, Last)	Galvin				2. Date of Dea Month	th Day	Year 06	3. Time of I	Death p M
/Medica Examine	er	4a. Facility Name (II not institution, give street 619 Admiral Drive,	and number) 404		4b. City, Town, or Annapo		1	Anı	y of Death ne Aru		
Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	June 18	Year)	Cour	place (State or ntry) ginia	Foreign
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	Funeral Director	Ar	el Ar	napo]	is	1401 spanic Origin? (S n, Mexican, Puen				an Indian,	
Maryland 21215-0036 Id 2 should be lifed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	Completed by F	3 XWidowed 4 □ Divorced Ye 15. Decedent's Education (Specify only highest grade com	res, Give par or Dates: WWII	16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired,	luring most of wo	rking	Special Specia		dustry	
	To Be C	17. Father's Name (First, Middle, Last) John A. Galvin				Addie M	ne (First, Middle, argaret	Gardneı	=		
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is merked any injury or other traumatic events.	12	19a. Informant's Name/Relationship (Type, Pr Christine Ennis (Da: 20a. Method of Disposition	ughter)	619 A	g Address (Street a Admiral Di sition (Name of				MD 21	L401	
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: if item: Iny injury or other		1 Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	al from State cen	netery, cren vland	Vet. Cem	. 4-18	-2006	Crownsv	-		
Department of the partment of		23a. Part 1. Enter the disease, or complication	s that caused the death.		Name and Addres Hardesty 12 Ridge. The mode of dying	<u>ly Avenu</u>	e, Annap	olis, N	1D 214	Approximate	
876(ate be hysicie the bur	dical Examiner	Sequential, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Oue to (or as a conseque	nce of):	olon can	ucer				Interval Betw Onset and D	eath
.O. BOX 6 the death certific y the attending p	Physician/Me	in the past 12 months?	yes, outcome of pregnand □Live birth 2 □ Fetal d □Pregnant at time of dea □Unknown	eath 3 □	Ectopic pregnancy Other (specify)				ate of delive onth	•	ear
Cords, P.O.	<u>م</u>	Part II. Other significant conditions contribut	ng to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th		eath? nknown
of Vital Records, hysician: The law requires this certificate has been signed idirector, page 2 should be	Completed						24a. Was a autops perfor 1 ☐ Yes	sy	prior to condeath?	psy findings a mpletion of ca 2 No	vailable use of
on C	Certification; To Be	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28	a. Date of Injury (Month, Day Year) 2. Place of Injury - At home	8b. Time of Injury	M 1 🗆 Y	or: 4 ☐ Nursing F	ath (Check only or dome 5 Residual 28d. Describe has 28f. Location (S	ence 6 ⊡Ot ow injury occu	rred		99 <i>r</i> ,
2 2 3 2 2		29a. Certifier (Check only 2 Medical Examiner: C	building, etc. (Specify) To the best of my knowl	edge, death	occurred at the time	ne, date and place	City or Town	ause(s) and m	nanner as si	tated.	<u></u>
To the Hospital within 24 hours e To the Funeral completely filled	Medical	29b. Signature and title of certifier L CLANN	nd manner stated.		29c. License	number		9d. Date sign		Day, Year)	
Sta Registra		30. Name and address of person who completed the street of	ed cause of death (Item 2	Map	DILS, MD	21401	Div.	Cathle	?en	A. Ke	mmer

			For State Registrar	State	of Marylan		artment rtificate			and M	_	giene Reg. No:	006	The second of th	04
			Decedent's Name (First, Middle	, Last)							2. Date of De	ath	Vana	3. Time of E	Death
	Physicia		Isabella	Marie	Car	idad		Gas	ch		April	Day 8	2006	12:30	a™
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, T	own, or	Location o	f Death		4c. (County of Dea	th	
			Anne Arundel M	edical Ce	enter		Ann	apo1	is			A	Anne Ar	undel	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Biri	thplace (State or buntry)	Foreign
	Director	ļ	unknown	1 □ M 2 💢 F		Yrs.			23	57	April	7,200		ryland	
	pu 🔭		Usual Residence of Decedent 10a. State 10b. County	-	10c Cit	v. Town or Lo	cation							10d. Inside City	v Limits
	anyla •ho	5	,	Arunde1		st Riv								1 □ Yes	
	the N	ect	10e. Street and Number	Ardider	WC	SC KIV	10f. Zip	Code				10a Citiz	en of What Co	untov?	
	with	ä					101. 2.0		770			.og. o		,	
	death with the Maryland me 23a or 28a-f ehow r must be twitted at	Funeral Director	1025 Allen Ave		edent Ever in U	S. 13.	Was Decede		778 Spanic Ori	ain? (Sp	ecify Yes or No	_ 1	USA 4. Race - Ame	erican Indian,	
_	Itan	E	1 Never Married 2 ☐ Marr	Armed F	orces? 2X No	i i	_		, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	e, etc.	
2	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1□Yes 2	XXvo	Specify:				Specify: Wh	ite	
212-0036	a filed within 72 hours after il Hygiene. other then "natural", or Ita vent. It e Medicel Esacutes	Completed	15. Deceden	's Education		16a. Dece	dent's Usual	Occupa	tion	e of work	ina	16b. Kir	nd of Business	/Industry	
<u></u>	hin 7	pje	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of worl DO NOT use	e retired)	uning mos	OF WORK	ing .				
N	giene giene er th	S	0			N/A						N,	/A		
2	al Hy al Hy 1 oth	Be (17. Father's Name (First, Middle,								e (First, Middle,	Maiden :	Sumame)		
yland	Mental Mental arked o	2	Blaine B. Gasc								M. Hall				
ā	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. I fleatith and Mental Hygiene after 28 or 28 or 28 or 10 the filem 27 is marked other than "natural", or Itame 28 or 28 or 28 or 10 the traumatic event. If a Medical Exaction or must be invitible.		19a. Informant's Name/Relations		`						al Route Numbe			Zip Code)	
e e	Health Health tem 27 other tra		Blaine B. Gasc	h (Father					nue,		t River			T	
0	ges 1 ar t of Hea If item or other		20a. Method of Disposition KXBurial 2 Cremation	3 Removal from		Place of Dispo cemetery, crea	natory or oti	e or her place				20c. Loc	cation - City or	Iown, State	
Ē	Pac tmen tant: jury		`4 □Donation 5 □ Other (S	pecify)		llcres					-2006		apolis,	MD	
Бащтог	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service	рісерѕее		22	Hard	Address esty	s of Facilit Fune	ra1	Home,	P.A.			
	00200			-0		b D							ille, M	D 20765 Approximate	
	7 ¥		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.		1						,	Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Hy	Doxic	Isc	hem)c	Zno	ep	halop	at	hy	10	
	/Medical Examiner		, 332,	Due to	Doxic oras a conseq 1+15ys	juence of):				1	- /		/	1 1	
	lat.	-	Sequentially list conditions,	b. /// but to	(or as a conseq	tempe of):	OV	ga	n	t	ailur	e		1 d	
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<			Ì	~							
_^	execu n and al-tra	Xai	that initiated events resulting in death) Last	Due to	(or as a conseq	juence of):									
2/PU	certificate be executed ding physician and ise as the burial-transit	cail													
Q	ificat g phy as the	ed													
XOD	leath certifica attending ph	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Tenania ara					2	3d. Date of de	livery	
מ	death e atten	icia	in the past 12 months? 1 ☐ Yes 2 No	4☐Preg	birth 2 🗍 Feta nant at time of d]Ectopic pre] Other (spe						Month	Day Y	ear
j Ö	if the by th tache	hys	9 Unknown	9□ Unkr	nown										
S,	w requires that the de been signed by the should be detached	ру Р	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying ca	iuse give	n in Part I		23e. Did to		4	the cause of de	ath?
ord	w require been sig should b										10	res 2	No 3□P	robably 4 🗍 Ui	nknown
ပ္	law reas beas beas 2 sho	piet									24a. Was		24b. Were at	utopsy findings a completion of ca	vailable
r	0 1 0	Completed										rmed?	death? 1 ☐ Yes		
<u>a</u>	ician: Th certificate ector, pag	BeC	25. Was case referred to medical						26. Place	of Deat	n (Check only o				
>	S S	To	examiner? 1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3□ DO	A Othe	r: 4 □ Nu	rsing Ho	me 5 Resid	dence 6	Other (Spe	cify)	
TO C			27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date (Mor	of Injury nth, Day Year)	28b. Time o Injury	f 28	c. Injury Work	at ?		28d. Describe I	now injury	occurred		
0	Attending r death. ector: After by the fune	ati	2 ☐ Accident investig	gation			М	1 🗆 Y	′es 2 🗌	No					
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could and determined	ined 286. Plac	e of Injury - At hiding, etc. (Specif	ome, farm, str fy)	eet, factory,	, office			28f. Location (3 City or Tox			ural Route Numb	1 <i>0r</i> ,
	ital c rrs af ral D														
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical	g Physician: To th Examiner: On the	basis of examina										
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifie		nner stated.		290	License	number			29d Date	signed (Mont	h Day Year)	
	S S S S S S S S S S S S S S S S S S S		200. Signature and tipe of certifie							<i>C</i> 1	1				1
			1/1	MD				10	715	5		Upi	1/ 13	, 200	6
			1/1/1	who completed cau	use of death (Iter	п 23а) (Туре,	Print)	000							
		•	31 Date filed (Month, Day, Year)	ann Li	egistrar's Signa	atul	PTTY	710							
	Sta Registr		APR 1	9 2006	egistrar's Signa	DA	ASSESSED NO.								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Man	•	artment of Heartificate of De		ental Hygie	2000	05
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
п	Physicia /Medic		AUDREY ODET	TA	GUNKEL		A	pril 19,	2006 Year	12:00 A M
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or Lo	ocation of Death		4c. County of Deat	
			Genesis Elder Care			La Plat			Char1	
	Funeral Director		213-30-1291	7. Age (f.	n yrs. last birthday) 93 Yrs.	If Under 1 Year III Months Days I	Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 3,	1912 Ma	hplace (State or Foreign untry) ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	Maryland Charles		Charlo	tte Hall				1 ☐ Yes 2 💢 No
	r 28a	Funeral Director	10e. Street and Number		CHAI TO	10f. Zip Code		10g.	Citizen of What Co	untry?
	h wit	a D	8735 Pebble Place			2062	2		USA	
	ems ;	ner		2. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spec Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland she : than "cratural", or Items 23a or 28a-f show the Marical Examinar must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give			Specify:			hite
21215-0036	hours tural'	q pa	3 Widowed 4 ☐ Divorced 15. Decedent's Educe	Year or Dates:	16a Decer	dent's Usual Occupation	20	161	b. Kind of Business/	Industry
15	in 72 n na	Completed	(Specify only highest grade	completed)	(Give	kind of work done duri DO NOT use retired)		g loc	o. Ring of business	moderny
212	r than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Ho	memaker			Own Home	e
פַ	be filed ital Hygi of other event, I	Bec	17. Father's Name (First, Middle, Last)			18	8. Mother's Name	(First, Middle, Mail	den Sumame)	
<u>Ja</u>	should b and Menta marked umatice	70	Tildon Bennett				Laura T	olson		
Maryland			19a. Informant's Name/Relationship (Typ			ng Address (Street and			ATTAL CONSCIONATION	of consense
	of Health of Health Illem 27 I		Betty L. Schutt -		8735 20b. Place of Dispo	Pebble Pla			. Location - City or	
Baltimore,	permit. Pages. Department of Important: If Ite any Injury or of		1 🗷 Burial 2 ☐ Cremation 3 ☐ Re	1	cemetery, crer	natory`or other place)		1		
ᄪ	nit. Pa artmen ortant: Injury E.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee	MO(en Mem. Pa			en Burnie	
Ba	Depa Impo any I		Mark H Bur	Kaun		untt Funer			Washing Waldorf	ton koad , MD 20604
			23a. Part1 Enter the disease, or complic	ations that caused the						Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	100	montin				Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	runs.	P	Α Λ	. /	
	Examiner		Sequentially list conditions, b.			ngestwe	e nec	ur- pa	ume	
-	p is	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a c	onsequence of):	8	to 11	-1		
	and I-trans	xam	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence do:	il wie	10 lu	rive.		
8760,	cate be executed physicien and the burial-transit	al E		20010 (0. 2020						
687	ficate physis the	edical	d.							
Вох	death certific e attending p id for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of j		ne .			23d. Date of deli	ivery
	0 0 0	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de	hys	9 Unknown							
Ś	8 5.0	þ	Part II. Other significant conditions cont	nbuting to death but r	not resulting in the u	nderlying cause given i	in Part I.	23e. Did tobac		the cause of death?
Ö		ompieted						24a. Was an		ton ou findings qualible
Rec	e la has	d L						autopsy performed	prior to death?	topsy findings available completion of cause of
ī		e Co	25. Was case referred to medical			2	6. Place of Death	(Chack anhy ana)	No 1 L Yes	2□ No
>	Physician: this certific ral director,	ToB	examiner?	spital:	2 ER/Outpatier	Other	1	1	e 6 □Other (Spec	cifv)
סר	iding Phys th. : After this : funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of			8d. Describe how		,
jo	Attending r death. actor: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 52)	out, Injury		s 2 □No			
Division of Vital Record	F 9 F C	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, Jarm, str Specify)	eet, factory, office	2	8l. Location (Stree City or Town, S	t and Number or Ru tate)	iral Route Number,
	To the Hospital or Atten within 24 hours effer deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physi (Check only one)	er: On the basis of ex	camination and/or in	n occurred at the time, vestigation, in my opin	date and place, a	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner stated		29c. License n	number	29d.	Date signed (Monti	h, Day, Year)
	⊬≯⊢ŏ		1			.D 1	4573	37 .	4/19/01	
(30. Name and address of person who con	pereted cause of deat	h (Item 23a) (Type,	Print)	, ,		,	0 4
1	33		Nirmala	dois v	ayanth	an, 33	28 0	ldwax	thing to	en Rel
3	Sta Registr		31. Date filed (Month, Day, Year) APR 2 0 2	32. Rigistrar's	Signature	harry				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Separtment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year April Margarita R. Garcia 12, 2006 3:10 a^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Nura 540 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 10,1958 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🔀 F 229-17-9540 47 Yrs. Honduras Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802 Denley Place 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Honduran 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jose Hernandez Anita Marquez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salvador Garcia / Husband 2802 Denley Place, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 4/19/2006 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Gastric Cancer disease or condition resulting in death) Years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested in the cause). Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 25 27.

Examine or Attending Physicien: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical Completed by this certificate Be Certification: To After y To the Hospina. ...
within 24 hours efter death.
To the Funeral Director: Aftr Medical

Physician

/Medical

Examiner

Funeral

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.
ortant: if item 27 is marked other then "natural; or iteme 23a or 28a-f show folly or other traumatic event. Its Marical Examinat must be notified at

permit. Pages Department of Important: If It eny injury or o once.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

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25.	Was case referred to medical			26. Place of De	ath (Check only one)
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	nt 3 🗆	DOA Other: 4 Nursing H	lome 5□ Residence 6 ØOther (Specify) Hospice
27.	Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation		of M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
	3 Suicide 6 Could not be determined		reet, fact	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29	a. Certifier 1⊠ Certifying Pl (Check only 2 Medical Exam one)	nysician: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.	h occurr ivestigat	ed at the time, date and place ion, in my opinion, death occu	, , and due to the cause(s) and manner as stated urred at the time, date and place, and due to the cause(s)
29	o. Signature and title of certifier			29c. License number	29d. Date signed (Month, Day, Year)
	Miliely	<u> </u>		D42452	April 12, 2006

State Registrar

31. Date filed (Month, Day, Year) APR 19 2006

Chitra Rajagopal, M.D.

30. Name and address of who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road; Rockville, Maryland 20850 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14, 2006 **Physician** 10:45AM Gilmore Ε. Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rebecca House Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 23, 1929 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 X F 275-26-3202 Director 76 Ohío Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or Itams 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Fairfax Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9036 Ashmeade Drive 22032 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be filt Department of Haalth and Mental Hy Important: If tiem 27 Is marked oth any injury or other traumattc aven once. Joseph Balough Marietta Morris 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9036 Ashmeade Dr. Fairfax, VA 22032 Orris F. Gilmore Jr. 20b. Place of Disposition (Name of cemetery, crematory or other pi 20a. Method of Disposition Date 20c. Location - City or Town, State place 1 Surial 2 Cremation 3 Removal from State Arlington National_{5/10/2006} Ft. Myer, VA * 4 □Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Fairfax Memorial Retu I 9902 Braddock Rd. Fairfax, VA 22032 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anterial Insufficiency Cerebrol 5 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signad by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) ASS: \$164 1 ☐ Yes 2. No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune 2 Accident investigation 1 □ Yes 2 □ No 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

W

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2006

Robert F. Byrne,

APR 19

31. Date filed (Month, Day, Year)

10009317

2333 S. Nash Street; Arlington, VA 22202

4118/06

			State of Maryland / Department of Health ar 1 - Registrar Certificate of Death	•		2 9 006	108	
	Dhusis		1. Decedent's Name (First, Middle, Last)	2. Date	of Death	Day Year	3. Time of Death	
	Physici /Medi		JOSEPH SIMON GOTS	Apri		6 2006	7:00A M	
	Examin	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I			4c. County of Death		
			Renaissance Gardens at Riderwood Silver Sprin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		of Birth	Montgome		
	Funeral Director			Min. (Mon	of Birth th, Day, Yes 12, 1	917 Phil	place (State or Foreign Intry) Ladelphia, PA	
Baltimore, Maryland 21215-0036	nylan ihow	_	10a. State 10b. County 10c. City, Town or Location		-		10d. Inside City Limits	
	8a-fs	octo	Maryland Montgomery Silver Spring				1 ☑ Yes 2 ☐ No	
	with th	by Funeral Directo	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	intry?	
	eath 18 23	erai	3142 Gracefield Road, Apt #107 20904 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	2 (Specify Vec		J.S.A. 14. Race - Amer	ioan Indian	
	within 72 hours after death with the Maryland ene. then "neturel", or ttems 23e or 28a-f show the Madical Exacility of wat by multiply at	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married	Puerto Rican, et	c.)	Black, White	, etc.	
		l by	If Yes, Give 1 ☐ Yes 2 ☑ No Specify:			Specify: White		
		Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working	16b.	Kind of Business/Ir	ndustry	
	within ane. then	mpi	Elementary/Secondary (U-12) College (1-4or 5+)			Medical	School	
	filed y Hygie other i	ပိ		s Name (First, M	fiddle. Maid		3011001	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The maryland of the them 21 is marked other them. The maryland at any injury or other them any injury or other treumetic event, it is madical Examination at the multilised at once.	To Be			Solomo			
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route I	Vumber, Cit	y or Town, State, Zi,	ip Code)	
			Selma S. Gots/Wife 3142 Gracefield Road	, Apt#1	07, S	ilver Spr	ing,MD 2090	
	Tite of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		Location - City or T		
	Pag ment ment ury		*4 Donation 5 Other (Specify) Ft.Lincoln Crematory 04	4/18/200	06 Bre	ntwood, N	Maryland	
Bail	permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES—RINALDI FUN 11800 New Hampshi	NERAL HO	OME, I	INC. ver Spring	g, MD 20904	
of Vital Records, P.O. Box 68760,	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or indition a. Cerebrovascular Disease resulting in death)	rdiac or respirat	tory arrest,		Approximate Interval Between Onset and Death	
	death certificate be executed e attending physician and infor use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (the sade or hithry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):					
	at the death certifics by the attending phatached for use as the	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		_	23d. Date of deliv Month	rery Day Year	
	ss tha		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
	w require s been si should t	iete	Delirium	24a.	Was an	24b. Were auto	opsy findings available	
	cien: ertifica ector, p	Completed	Atrial Fibrillation & Popurrent Urinary Infoation			opsy prior to completion of cause of death? 2 ☒ No 1 ☐ Yes 2 ☐ No		
		To Be	or West and office days of the second	Death Check		10 100	2010	
			1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)					
			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? M 1 Yes 2 No			escribe how injury occurred		
		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Locat City o	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospit within 24 hour To the Funer completely fills	edical (29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	To the within 2 To the complet	Me	29b. Signature and title of certifien 29c. License number		29d. D	ate signed (Month,	Day, Year)	
	17/		D-23649		Ap	ril 17, 2	006	
	10		30. Name and address of derson who completed cause of death (If m 23a) (Type Print) John Stuckey, MD, 3110 Gracefield Road, Silver Spring, Maryland 20904					
į	Sta Registr		31. Date filed (Month, Day, Year) APR 19 2006 32. Projectors Signature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year 12:00 Gay Gilkerson April 23, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | May 5, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1 ☐ M 2 🙀 F 233-88-1433 Yrs Director 92 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₹ No Director Maryland Calvert Prince Frederick 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 1530 Old Adelina Road 20678 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 ☐ Yes 2 ₩ No If Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other the eny injury or other traumatic event, ITE 9008. Disabled Handicapped 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Della Eppin Leon M. Gilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gilkerson/Sister In-Law 1530 Old Adelina Road, Prince Frederick, Maryland 20678 20b. Place of Disposition (Name of cometery, crematory or other place)
Pleasant View Memory
Cardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Martinsburg, West Virginia April 29, 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Nuchau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PARKINSONS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Yes 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsyl performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 2 🗆 No 1 Yes 1 Tes 25. Was case referred to medical examiner? director. Be 26. Place of Death | Check only one Hospital Other: 1 ☐ Yes 2 No Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this After this funeral of 27. Manner of Death 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L Medical 29a. Certifier ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, deat and place, and due to the cause(s) and mainter as sector.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) APR 2 5 2006

HOSPITPOL

29b. Signature and title of certifier



30. Name and address of person who completed cause death (Item 23a) (Type, Print) 6 LYN 15 A MOODY, MO

050233

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Wayne Hansford Michael APRIL 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Sep 11, Birthplace (State or Foreign Country) Months 1₩ M 2□ F 1961 213-82-7438 44 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1√2 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Arch Street 21502 USA 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white If Yes, Give ^ Year or Dates 3 Widowed W Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George H. Hansford Lalla R. Seiese Hansford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
314 Frederick Street Cumberland MD 21502 JoAnna Phipps daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 4/27/2006 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License ^{22. Name and Address of Facility} Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pay one cause on each line.

Physician /Medical **Examiner**

spitel or Attending Physicien: The law requires that the death certificate be executed toucs after death.

Line at Director: After this certificate has been signed by the attending physician and illed in by the funeral director, page 2 should be detached for use as the buriar-transit

Be Completed by Physician/Medical

Certification:

Medical

Box 68760.

Division of Vital Records, P.O.

permit. Page Department of Importent: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10a. State

MD

Funeral

Director

r then "natural", or Items 23a or 28e-f ehow the Medical Examinar must be notified at

Pages 1 end 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. shir if Item 27 is marked other then "natural", or Items 23, xry or other traumatic event, the Medical Exam that make

Baltimore, Maryland 21215-0036

with the Maryland

Examiner

Immediate Cause (Final disease or condition resulting in death) Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

INTRACRANIAL HEMORRHAGE Due to (or as a consequence of): LIVER FAILURE

Due to (or as a consequence of)

ALCOHOLISM Due to (or as a consequence of):

-27-Dia

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Approximate Interval Between Onset and Death

8 HOURS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

JAUNDICE

3 Suicide

29a, Certifie

4 Homicide

1 ☐ Yes 2 ☐ No 24a. Was an

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ★Unknown

autopsy performe 2 No 24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death | Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify)

25. Was case referred to medical examiner? Hospital: 1 Inpatient 27. Manner of Death 1. Natural 5 Pending 2 Accident

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 TYes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

DR. KHEDER ASHKER,

29c. License number D26471

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APRIL 26, 2006

State Registrar 31. Date filed (Month, Day, Year) MAY 0 3 2006

625 KENT AVE., SUITE 306, CUMBERLAND, MD 32. Haristrar's Signatu

Example 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21502

To the Hospitel o within 24 hours aft To the Funeral DI

Dhami		1 - State Registrar Amend Ite 1. Decedent's Name (First, Middle, La	ist)					2. Date Mont	Reg. I		3. Time of Death
Physic /Medi			FRANCES		ASTING				4	20 2	
Exami	ner	4a. Facility Name (If not institution, gir	ve street and numb	er)			or Location of D	eath	1	tc. County of I	Death
Funeral		UNION HOSPITAL 5. Social Security Number 6.3	Sex 7.	Age (In yrs. I	ast birthday)	ELKTO	If Under 24 I	Hrs. 8. Date	of Birth		Birthplace (State or Fore
Director	,		1□M 2□F	88	Yrs.	Months Days	Hours N	1-12	of Birth h, Day, Yea 2-19	ir)	VA VA
A =		Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation					10d. Inside City Lim
"natural", or items 23a or 28a-f ehow	to	DE SUSSE	X		GEORGE	TOWN					1 ☐ Yes 2 🛣 i
or 288	Funeral Director	10e. Street and Number				10f, Zip Code			10g. (Citizen of Wha	t Country?
238 Walt	ral	4 ROGERS AVE.				1994				USA	
lien Dec	nue	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decede Armed Force 1 Yes 2	s?	S. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin? ban, Mexican, Pi	? (Specify Yes uerto Rican, etc	or No- c.)		American Indian, White, etc.
al', or	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	••		□Yes 2X No	Specify:			Specify:	WHITE
	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	lent's Usual Occu	pation	working	16b.	Kind of Busin	ess/industry
r then	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	OO NOT use retire TRY INSP	∍d)			D(OULTRY
Hygie thert int.	e Co	17. Father's Name (First, Middle, Las.	1)		1001	TKI TROI		Name (First, M	iddle Maid		JULIKI
d o	To Be	JULIUS H. SHAY						. COLON		or, comanio,	
th and Mer 7 Is marks treumatic		19a. Informant's Name/Relationship			19b. Mailin	g Address (Stree				or Town, Sta	te, Zip Code)
f Health item 27 I other tre		ELIZABETH F. HA	ASTINGS			AUGUSTA	DR., NE				
or off		20a. Method of Disposition 1- Burial 2 ☐ Cremation 3 €	Removal from Sta	ate Ce	emetery, cren	sition (Name of natory or other pla		Date			y or Town, State
partmen portant: y injury		4 Donation 5 Other (Special Control of Contr		DOW		APTIST C		-24-06		OAK HAI	
Depa Impo any ir		21. Signature of Funeral Service Lice	A ST			Name and Addr				AL SERV	
2		23a. Part1. Enter the disease, or con	plications that cau	sed the death	. Do not ente	O9 E. MA or the mode of dy	ing, such as care	. GEUK diac or respirat	GETOW, ory arrest,	N, DE	Approximate
nysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	ensis	-						Interval Between Onset and Death
Medical		resulting in death)	aDue to (or								unbnow
xaminer	_	Sequentially list conditions, if any, leading to immediate	b. Cen	gestin	ie H.	eart fo	rilure				Unknow
sit	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or		ence of):						7/22 4
n and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ		5 -					Teans
hysicien and the burial-transit	Cal	(d								
ng ph	ed	IF FEMALE:									
e attending ph id for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?		1 2 ☐ Fetal	death 3□	Ectopic pregnanc	у			23d. Date of Month	delivery Day Year
y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnani 9□ Unknowr	t at time of de	oath 5∟	Other (specify) _			-	Month	Day Toal
igned by the a be detached (Part II. Dther significant conditions	contributing to deat	h but not resu	Iting in the ur	derlying cause gi	ven in Part I.	23e.	Did tobacco	use contribu	te to the cause of death?
as been signed b 2 should be deta	ed by							_	1 🗌 Yes	2□No 3□	Probably 4 Unknow
s been s 2 should	plete								Was an	24b. Wer	e autopsy findings availat
ate hi	Completed							1 U Y	autopsy performed? ′es 2.∰t	deat	to completion of cause of h? Yes 2 \(\sime\) No
this certificat	Be (25. Was case referred to medical examiner?	I de ceitele			- I a		Death Check of	AL,		
this c	2	1 ☐ Yes 2 ☑ No 27. Manney of Death	Hospital: 1 Linps		ER/Outpatien 28b. Time of	3 DON		g Home 5			Specify)
r death. ector: After by the funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	28c. Inju	ork?]Yes 2∐No	280. Desc	ribe now in	ury occurred	
death ctor; /	Certification;	3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho	me, farm, stre	et, factory, office					r Rural Route Number,
- 60	Cert	4 Hornicide	building,	etc. (Specify)			City o	r Town, Sta	ite)	
s after el Dire ed in by		(Uniock only 2 Medical Exa	nysician: To the be	st of my knows	vledge, death	occurred at the t	ime, date and pl	ace, and due to	the cause	s) and manne	r as stated. due to the cause(s)
4 hours after Funerel Dire ely filled in by	.2	one)	and manner	stated.		29c Licen	ca number		304 F	ata signad /l	Innih Day Yearl
thin 24 hours after the Funerel Direct Impletely filled in by	Medical	29b Signature and Mile of certifier				230. LICOII	-5		25U.L	wo Jigiiou (N	onni, pay, roarj
Dir	Medio	29b. Signature and Mile of certifier	1/5 111			וחור	02332	2_	4	421/1	26
within 24 hours after To the Funerel Direct completely filled in by	Medic		V S M)	of death (Item	23a) (Tyne 1	Do (02332	2_	4	7/21/0	06.

			1 - For State Registrar	State of Maryla		artmen rtificat			and M	lental H	ygien	2 U U	6	***	12
5	Physic	ian	1. Decedent's Name (First, Middle, Las							2. Date of D)ay	Year	3. Time 2:55	of Death
	/Medi	cal		nia Temple H	lolden		_	. ()		April	24,	2006			A M
73	Exami	ner	4a. Facility Name (If not institution, give					Location of	of Death		4	lc. County			
	Funeral		21184 Coltons Pos 5. Social Security Number 6. Se		rs. last birthday)	Ave If Under		If Under	24 Hrs.	8. Date of E	Birth		Mary		e or Foreign
17	Director			⊒м 2 ∏ F	69 Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, L November	^{рау, Ува} r 8.1	936	Virgi	intry)	or i orongii
	pu ,		Usual Residence of Decedent	10-	O. T.										
	ehov	5	10a. State 10b. County		City, Town or Lo	ocation								10d. Inside	City Limits
	72 hours after death with the Maryland natural', or itema 23a or 286-f ehow dical Examinar must be notified at	Funeral Director	Maryland St. Mary	'S	Aver	10f. Zip	Code				10= 6	Citizen of	Mb-A Co.		XX
	Sa or	급		n+ Dood								USA	Winat Cot	ititiy r	
	death ma 2;	era	21184 Coltons Poi	12. Was Decedent Ever in	n U.S. 13.		0609 lent of Hi	spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)			e - Ameri	can Indian,	
9	after or ite	Ē	1 □ Nøver Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X					. Puerto	Rican, etc.)			ck, White	etc.	
93	ours Fal',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2	ZIX NO	Specify:				Specif	Whi	te	
7-	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usua kind of woi	k done d	urina most	t of worki	ing	16b.	Kind of B	usiness/lr	ndustry	
121	filed within Hygiene. ther then " int, the Me	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	1	<i>DO NOT us</i> les M					T.	ewelr			
9	filed Hygin ther		12. Tather's Name (First, Middle, Last)		Ja	ies n	anag		ır's Name	e (First, Midd			-		
lan	lid be lental ked c	To Be	James Welford Bas	bv				Eli ₂	ahet	h Fran	ncis	Ware	,		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. It has not Mental Hygiene. Itam 27 is marked other then "natural", or itema 23a or 28e-f ehow other treumatic event, The Medical Exempter treumatic event, The Medical Exempter toward.	-	19a. Informant's Name/Relationship (T	4	19b. Mailin	ng Address	(Street a			Al Route Num				Code)	
	ss 1 and 2 of Health a itam 27 is othar tree		Louis Holden / Husbar						Maryl	and 2060	09				
ore			20a. Method of Disposition 1 TyBurial 2 Termation 3 Till	200	o. Place of Dispo cemetery, crei	sition (Nam matory or o	ne of ther place	9)	Api	ate il	20c.	Location -	City or T	own, State	
Ë	Pages ment of h lant: If its		4 □Donation 5 □ Other (Specify		11 Saints	Cemete	ry		_	2006	Ave	enue,	Maryla	and	
Baltimore,	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Licens	Hardine	Me P.	Name and atting! O. Box	d Address ey-Ga 270,	s of Facility rdiner Leona	Fune	eral Hom Vn, Mary	e, P. land	A. 20650			
¥.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dine cause on each line.	Do not ent	er the mode	e of dying	, such as	cardiac c	or respiratory	arrest,			Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	a ATHYT	HMA	5								Onset and	d Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of): MIC C	A		. 524	-T 211	/				Ven	2.0
		20	Sequentially list conditions,	b. Due to (or as a cons		41018	, 0 ,0	YUM	CZC	7				1000	4
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a cons	sequence of):										
8760,	sate be shysicit the bu	dicai	(d											
39	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:												
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1☐Live birth 2☐F	etal death 3 [Ectopic pre							te of deliv	ery Day	Year
0	he de the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	of death 5□	Other (spe	ecify)	·				1010		Duy	1 041
P.O.	res that the de igned by the a be detached t		Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use cont	ribute to t	he cause of	death?
of Vital Records,	uires sign	d by	CONGEST!	VE KEATL	T FAR	une				1 🗆	Yes 2	2 🗆 No	3 ☐ Prol	ably 4/	Mnknown
00	aw requir as been si 2 should	lete	COPY	>						24a. Wa	s an	24b. 1	Nere auto	psy finding	s available
æ	The is ete ha page 2	Completed								per	opsy formed?		prior to co death?	mpletion of	
ital		Be C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only		0	☐ Yes	2010	
>	d is	ToE	examiner? 1 ☐ Yes 2 D No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	it 3□ DO	A Othe	r: 4 🗆 Nur	rsing Hor	ne 5DAes	sidenc <i>e</i>	6 □Oth	er (Specii	(y)	
ū	ding Ph ^{n.} After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28	Bc. Injury Work	at ?	2	28d. Describe	how inj	ury occur	ed		
Sio	Attending in death.	cati	2 Accident investigation 3 Suicide 6 Could not be			М		es 2□N							
=	of or Attency after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str <i>icily)</i>	eet, factory,	, office		4	28f. Location City or To			er or Rura	al Route Nu	mber,
_	• Hospital 4 24 hours a • Funeral C etely filled i		29a. Certifier 1 Certifying Phy	sician: To the best of my k	theah anhalwon	occurred a	at the time	n date and	d place is	and due to the	0.03450/	s) and ma		totad	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	ination and/or inv	vestigation,	in my opi	inion, deat	h occurre	ed at the time	, date ar	nd place,	and due to	the cause	(s)
	To the To the Complet	Ž	29b. Signature and title of certifier			29c.	License				29d. D	ate signe	(Month.	Day, Year)	
)				h	くり		DIE	309	6		Apı	ril 25	, 200	5	
			30. Name and address of person who co												
45	ilir		Rajbinder Gill, M.D. 31. Date filed (Month, Day, Year)	26840 Point Lo		d, Leor	nardto	own, M	aryla	nd_20650)				
* 2	Sta Registr		APR 2 5 2006	32. Registrar's Sig	Jirature Joseph	U									

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mary		artment o				Reg. No.	6	4113
	Physici	an	1. Decedent's Name (First, Middle, Last						2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Ella Buchanan He			# 5" T				22, 2006		4:57 A M
	Examir	er	4a. Facility Name (If not institution, give 23961 Hollywood R			4b. City, Tov			ath	4c. County o		
	4 %	Yic."	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Y	11yw	OOD Under 24 Hr	s. 8. Date of Birt	St. Ma		ace (State or Foreign
Б.	Funeral Director		217-30-0773	_M 2₹ F	99 Yrs.			lours Mil		y, rear)	Counti	nv)
			Usual Residence of Decedent						NOV LO	1,500	aryr	anu
	how		10a. State 10b. County	100	c. City, Town or Lo	ocation					10	d. Inside City Limits
	a-f s	cto	Maryland St. Ma	ry's	Ho1	lywood						1 ☐ Yes 2X☐ No
	or 28	Oire	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of Wh	nat Count	ry?
	ath w	Funeral Director	23961 Hollywood R				206				SA	
	tems	nue	11. Marital Status	 Was Decedent Ever Armed Forces? Yes 2 No 	in U.S. 13.	Was Decedent If Yes, specify	t of Hispa Cuban, N	nic Origin? (lexican, Pue	(Specify Yes or No arto Rican, etc.)	14. Race Black	 America White, e 	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give		1 □ Yes 2 🛣	No S	pecify:		Specify:	Blac	k
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Exanaler must be indiffed at	pe pe	15. Decedent's Edu	Year or Dates:	16a Dece	deni's Usual O	ocupation	2		16b. Kind of Bus	iness/Indi	uetni
5	in 72 in na	Completed	(Specify only highest grad	le completed)	(Give	kind of work a	done durir etired)	ng most of w	orking	TOO. KING OF DUS	111033/11101	astry
12	l within iene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	He	ousekee	per			Private	Home	es
D	e filed vill Hygie other i	BeC	17. Father's Name (First, Middle, Last)				18.	Mother's N	ame (First, Middle,	Maiden Sumame)	
a	should be and Mental s marked o umatic eve	To B	Frank Buchanan					Julia	Sherk1if	f		
Maryland 21215-0036	and Ma s mark	-	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address (St	treet and	Number or I	Rural Route Numbe	er, City or Town, S	tate, Zip (Code)
Σ	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mantal Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, ite Medical Exam.		Ella Neal / Daugh		The second second second			Road	Hollywoo	d MD 206	36	
ore	of He		20a. Method of Disposition 1 ABurial 2 Cremation 3 1		Ob. Place of Dispo cemetery, crei	sition (Name of matory or other	of r place)		Date	20c. Location - C	ity or Tov	vn, State
Ē	Pag ment ant: Jury c		4 ☐ Donation 5 ☐ Other (Specify)		Charles Me	morial G	arden	s Apr	26, 2006	Leonardt	own,	MD
Baltimore,	permit. Pages 'Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licens	Hardiner	2	2. Name and A Mattin P.O. 1	ngley.	-Gardin	er Funeral nardtown, M	Home, P.A. D 20650		
*			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do not en	er the mode of	f dying, s	uch as card	ac or respiratory ai	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Cander	Reller	Jam		RMO	T			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):							
	LAGITITIE	_	Sequentially list conditions,	b. Metanto	De	(au	N	em	2			
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as al co	nsequence of):							
•	xecut and al-trar	Examine	that initiated events resulting in death) Last	cDue to (or as a co	nsequence of):							
8760,	ate be executed thysicien and the burial-transit	icalE										
687	death certificate be executed e attending physicien and nd for use as the burial-transit			d								
Вох	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr						23d. Date	of deliver	у
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at time]Ectopic pregr] Other (specif				Mont	th [Day Year
P.0	that the de led by the a	hys	9 Unknown	9∐ Unknown								
	8 5 9	by F	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying caus	e given ir	n Part I.		bacco use contrib		
Vital Records,	w require been sig should b								10	res 2.₽No 3	Proba	ibly 4 Dunknown
ပ္ပ	elawr hasbe je 2 sh	pie							24a. Was autop	sy pr	ere autop	sy findings available
<u> </u>	T afe	Completed							perfo 1 ☐ Yes		ath? ☐ Yes 2	2 🗆 No
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Unanitali.				. Place of D	eath (Check only o	ne)		
of	Physicien: this certific ral director,	မ	To res 2 to see	Hospital:	2 ER/Outpatier			4 Nursing	Home 5 side			
E	ding 1 h. After funer	lo Lo	27. Manne of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	M 28C.	Work?	2 🗆 No	28d. Describe i	now injury occurre	a	
Division	Attanding r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, st			2 110	28f. Location /	Street and Number	r or Rural	Route Number
ē	el or A s after st Dire	Certification:	4 Homicide determined	building, etc. (S	pecify)	out, radioly, or			City or Tox			
	To the Hospitel or Attanwithin 24 hours after deatl To the Funarel Director:	Medicai (29a. Certifier (Check only one) 1 ★ Certifying Phy 2 ★ Medical Exam	rsicien: To the best of mainer: On the basis of exa and manner stated.	y knowledge, deat amination and/or in	h occurred at t vestigation, in	the time, o	date and pla on, death oc	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as sta nd due to	ited. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	- [- ~		icense nu	_		29d. Date signed	(Month, D	Pay, Year)
			of ounder	i hor	me	00	917	-		4/24	106	
			30. Nam and ad ress of person who c		(Item 23a) (Type,	Print)	20	م. <i>ا</i> الـ الـد	, (n = 1	~/	•
			31. Date filed (Month, Day, Year)	CON Cinl	Signatura	DUX 1	7.	ricinge	Wood. In	V 206	36	
4	Sta Registi		APR 2 5 2	32. Registrar's	Je a	Card .		•				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] [] [Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) . Day 2006 April 17, Year **Physician** \mathbf{T} . Hayden, 12:00a M Byron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Nursing Home Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or For County) | Min. | Sept. 22, 1916 | Washington, 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 214-03-8343 89 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Maryland Montgomery 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3005 S. Leisure World Blvd., #712 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 ie marked other than "neturet", or item eny injury pe pither treumatic event, the Mudical Examinar once. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 No Specify þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) United States Tax Investigator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Byron T. Hayden, Sr. Ada Bayard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada-Ann Schmoker/ Daughter 5638 Inverchapel Road, Springfield, VA 22151-2026 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) April 20 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Cate of Heaven Cemetery 4 ☐ Donation _ 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signatur 1 Ineral Service Licenses Francis of Adres of Filths Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 Cobers CKa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 Week Renal Insufficiency /Medical Due to (or as a consequence of): Examiner Essential Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets) Due to for as a consequence of Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Parkinson's Disease, Cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes XXNo Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homacide t 🐰 Carrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 240 Cortifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

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with the Maryland

death v

Baltimore, Maryland 21215-0036

r than "neturel", or Items 23s or 28s-f show the Madical Exampler must be notified at

ettending physicien end for use as the burial-transit

been signed by the should be detached

s certificate has tallinector, page 2 s

filled in by

el or Attending Physician: T s after death. si Director: After this certificet ed in by the funeral director, ps

To the Hospital within 24 hours a To the Funeral Completely filled: Hospitei

use as the

requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

31. Date filed (Month, Day, Year) State Registrar

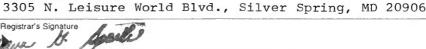
29b. Signature and title of certifier

Burt I. Feldman, M.D.



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006



29c. License number

D23958

29d. Date signed (Month, Day, Year)

April 17, 2006

		-	For State Registrar	State of Mar		artment of He <i>rtificate of D</i>	ealth and Menta Death	Al Hygiene Reg. No		15
	Physicia	an	1. Decedent's Name (First, Middle, Las				Mo	te of Death onth Da		3. Time of Death 9:49 P M
6	/Medic			shuch		4b. City, Town, or I		5PV 40	Z-06. County of Death	7-17 P M
7	Examin	er	4a. Facility Name (If not institution, give	ck Tawn	-Center	Baltr-	s re_		. Journal of Journal	
	Funeral	40	Social Security Number 6. S		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Da Hours Min. (Mo	te of Birth onth, Day, Year,	9. Birthp	place (State or Foreign
	Director		578-40-1751 Usual Residence of Decedent		82 Yrs.				1923 Pa1	estine
	land ow		10a. State 10b. County	1	Oc. City, Town or Lo	ocation			1	0d. Inside City Limits
	a-f sh	ctor	Maryland Howard		Lau	re1				1 ☐ Yes 2 💢 No
	vith th	Director	10e. Street and Number			10f. Zip Code			tizen of What Cour	itry?
	eath v	Funerai	8417 Shears Ct	12. Was Decedent Ev	er in U.S. 13.	20723 Was Decedent of His	spanic Origin? (Specify Yon, Mexican, Puerto Rican,	US A	14. Race - Amend	
396	within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show itte Medical Examinat must be indiffed at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Rican, Specify:	etc.)	Black, White, Specify: Wh	etc. iite
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d 2	H Pyg		17. Father's Name (First, Middle, Last)			Hostess	18. Mother's Name (First		Weis Mark n Sumame)	ers
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	s 1 and 2 of Health item 27		Sam Hishmeh/Son 20a. Method of Disposition		20b. Place of Dispo	osition (Name of	d, Fulton,		9 Location - City or To	own, State
nor	iit. Pages 1 and 2 should riment of Health and Men ritant: If item 27 Is marke injury of other traumatic		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			matory or other place leaven Cen		006 S	ilver Spr	ing, MD
altimore,			21. Signature of Euneral Service Lice		22	2. Name and Addres	s of Facility Hines-	Rinaldi	Funeral	Home
8	Per de pe) Was				lampshire Av		er Spring	
			23a. Part1. Enter the disease or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line		ter the mode or dying	L	matory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical /		disease or condition resulting in death)	Due to (or as a	ctivial consequence of): Subdural	TENINGT	(5.			1/2
	Examiner		Sequentially list conditions	D		Hem	tome		MIL	THE
1	pa sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):			2 46	BY MEDICAL EXAMINATION OF THE PROPERTY OF THE	ER
	ficate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):		^ .	RATE	BY MEDICAL	
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
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Vita	Physician: rthis certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 2 Yes 2 No	Hospital:	t 2 ER/Outpatie	ent 3C DOA Othe	26. Place of Death (Che er: 4 \sum Nursing Home		6 ∏Other (Speci	ifv)
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce		hysician: To the best of miner: On the basis of	f my knowledge, dea examination and/or ii	nvestigation, in my of	ne, date and place, and d pinion, death occurred at	ue to the cause ine time, date a	(s) and manner as	stated.
	To the within To the complete	Me	29b. Signature and title of certifier	1		29c. Licensi	e number	29d. C	ate signed (Month	
	5) CHO	~		L	16535		Apr 12,	2006
	_			completed cause of de	ath (Item 23a) (Type	o, Print)	Baltimore	. ~		
	S.	ate	Felix Lui 31. Date filed (Month, Day, Year)	32. Registra	r's Signature	- 31, j	e number 16535 Baltimere	•		
10	Regist		APR 19	2006	W 14 19	poser				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1- State Registrar Amended #23b per MD FCHD, KSCertificate of Death 4/20/06 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Herbert Marvin Hottinger April 14, 2006 3:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kline Hospice House Mount Airy Frederick 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 ☐ F 216-16-9862 85 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28e-f ahow traumatic avant, the Medical Examiner must be notified at 1x Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Victoria Square 21702 or iteme 23e United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. I other than "natural", or iter 1XXYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Year or Dates: WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter Remodeling/Restoration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be fi of Health and Mental H I Item 27 is marked otl Wilbur V. Hottinger Florence Virginia Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Raymond / Daughter 6 Victoria Sq. Frederick, MD 21702 20b. Place of Disposition (Name of comptony, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of t April 18, 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any injury or once. Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2006_ Frederick, Maryland Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is only one cause on each line. Approximate Interval Between shock, or heart failure. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC RENAL CELL CARCINOMA 5 WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physicien Physician/Medical thet use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. he 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🏋 No certificate has Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA this HOSPICE 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending Injury 1 X Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)0056314 BHIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINDU & DFGE 46 B THOMAS TOPIN JOHNSON DRIVE FREDERICK MD 21702 46 B MOMAS

DHMH 17 Rev 1/2001

Registrar

31. Date liled (Month, Day,

32. Registra Signature

0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** 8:12PM 5,2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** rince octors HOSPITA anham | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Worth | Worth | 14, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace **Funeral** 216-24-613 1 M 2 □ F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic avant, the Medical Examiner must be notified a 1 Yes 2 □ No Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 4304 20706 23a 12. Was Decedent Ever in U.S. Amed Forces? 1 Ves 2 □ No.2 -7-5 I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo BIACK If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) aintenan 10 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ant: If itsm 27 is marked o 0 elationship (Type, Pri t) 19b. Mailing Addrus (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If itsm 27 is
sny injury or other trau 4304 20706 Lanham, Mts Baltimore. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) lana 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. 2.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** Unknowy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Due to (or as a consequence of): Examine burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed? 2 No 1 Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗷 Inpatient 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medicai Certification: 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 1 Carthying Physiciam To the best of my knowledge idealn occurred at the time, date and place, and due to the date (s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 043446 M.D 4.16.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Ave Suit 3-41 Silve spring FARAH CAR MA REAL TAN 31. Date filed (Month, Day, Year) State APR 2 0 2006

DHMH 17 Rev 1/2001

Registrar

			1 - For Stete Registrar	State of Mar		artment of F			Reg. No.	8
	Dhysisi		Decedent's Name (First, Middle, L.					2. Date of De. Month	ath Day Year	3. Time of Death
	Physicia /Medic		CECILIA ADET					April	15 2006	2:50 A M
	Examin	er	4a. Fecility Name (If not institution, ga				r Location of Death	1	4c. County of Deat	
			Montgomery Hosp 5. Social Security Number 6.		ouse In yrs. last birthday	Rockvi	.11e If Under 24 Hrs.	8. Date of Birt	Montgom	ery hplace (State or Foreign untry)
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	land ow		10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
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	r 28s	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
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	ams ams	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race - Ame Black, Whit	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify: B1	ack
21215-0036	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show Gical Examiner must be notified at	g p	15. Decedent's	Year or Dates:	16a. Dec	edent's Usual Occup	ation		16b. Kind of Business	Industry
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10	nould be fill I Mental Hy narked oth	To B	Emmanuel Akino	la Caetano			Adline	Abegbe	01adapo	
Maryland	and N		19a. Informant's Name/Relationship			•			er, City or Town, State, a	
Σ	and 2 paith n 27		Jackson O. Ijel	u/Husband					Maryland 20	
ore	T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac		Date	20c. Location - City or	
Ë	Pag ment ment:		4 □ Donation 5 □ Other (Spec	eify)		Heaven Cer	1			ng, Maryland
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If item 27 is marked any injury or other traumatic avonce.		21. Signature of Funeral Service Lic	ensee	H H	12. Name and Addre INES-RINA 1800 New 1	ss of Facility LDI FUNEI Hampshire	RAL HOME Ave, S	, INC. ilver Sprin	g,MD 20904
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to annibulate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Breast O Due to (or as a			ig, such as cardiac	or respiratory a	irest,	Approximate Interval Between Onset and Death
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<u>ر</u>	es thal igned b	by P	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	tobacco use contribute to	the cause of death?
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Division	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Certification:	3 Suicide 6 Could not determine	be 280 Place of Injur	y - At home, farm, s (Specify)	street, factory, office	2-11	28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai		Physicien: To the best of aminer: On the basis of e and manner state	xamination and/or					
	To th within Fo th	Me	29b. Signature and title of certifier	_		29c. Licens	se number		29d. Date signed (Moni	h. Day, Year)
			トレスト	\sim $_{\cdot}$	20	D-356	35		April 17,	2006
	5		30. Name and address of person what Joseph Kaplan,			e, Print)		le, Mary	yland 20855	
	Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar	's Signature	Coast)		•		
	Regist		APR 19	2006	's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Edward Johnson 7, 2666 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KICOM 100 Keg 10 NAC SALBBU PENINSULA Madira If Under 1 Year | If Under 24 Ars. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (2-9-5 5. Social Security Number 214 - 60 - 947 **Funeral** Days 1 XM 2□ F Months Hours 53 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28e-f show ul Hygiene. . other than "natural", or items 23a or 28e-f shov vant, the Medical Examiner must be notified at 1 ☐ Yes 2 No BROA Completed by Funeral Director ICOMICO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21830 8009-USA ASHIELL KDAD liled within 72 hours etter deeth Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WHITHEYE DNSTAUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be lift iment of Health and Mental H tant: If itam 27 is marked oth Be JOHNSON ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EWMARKET MD 21631 HOLLYRD. JOHNSON ~ BROTHER or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MALONE CEMETER permit. Page Depertment of Important: If any injury or once. 4-22-06 BENNIE 21. Signature of Funeral Service Licensee ISABELLA ST. SALISBURG MD 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Hyper Kalemia Physician /Medical Due to (or as a consequence of): Acute renal Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ol) Examiner ettending physicien end for use as the burial-transit Attending Physician: The law requires that the death certilicate be executed resulting in death) Last Due to (or as a consequence of): ivision of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. iver pulmonar 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown U5100 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan alcoho abuse tobacco certilicate 2 No 1 Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 2 No Alter this funeral of 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 🗌 Pendina 1 Yes 2 No investigation naral Director: A filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours elter of To the Funaral Directory Completely filled in by 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tyle of certifier 29d. Date signed (Month, Day, Year) M D0062130 18 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anoia Dr. Salisbury Healthway 1104 ames 31. Date liled (Month, Day, Year) 32. Digistrar's Signature State 2006 Registrar

					State of Maryland /				-	-	Die.
		_		1 - For State Registrar			cate of l			eg. No.	6 14120
	7	Physic		1. Decedent's Name (First, Middle, Las William E	^{st)} lmo Johnson, J	r			2. Date of Deat	Day	3. Time of Death
	+	/Medi Exami					. City, Town, or	Location of Death	mpk) !	4c. County	/
		1 E		4a Facility Name (If not institution, given Upper Chesapea) Medical Center				Air		Har	ford
		Funeral Director		5. Social Security Number 6. S 179-50-4220 Usual Residence of Decedent	ex X M 2□F 7. Age (In yrs. last to 51		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 28	Year)	9. Birthplace (State or Foreign Country) Maryland
		ryland how		10a. State 10b. County	10c. City, To	wn or Locatio	n				10d, Inside City Limits
		filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28a-1 ehow int, the Medical Examinan the rediffed at	Director	MD Harfor ,10e. Street and Number	cd Bel		Of. Zip Code		1	Og. Citizen of V	1√2 Yes 2 No What Country?
		th with 23s o		504 Cressy Road	Apt. 504		21014				States
		ter death wi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Rac	e - American Indian, k, White, etc.
	336	urs aft	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		∕es 2√2 No	Specify:		Specify	
	5-0036	72 hours "natural", olical Exe	sted	15. Decedent's Ed (Specify only highest gra	ducation 16	a. Decedent's	Usual Occupa	ation		16b. Kind of Bu	Black siness/Industry
30	21	l within 72 hoiene. Iene. Ir then "natu	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			furing most of worki	ng		
2	d 21	be filed vital Hygie of other t	Be Co	12 17. Father's Name (First, Middle, Last)		Cafe	teria	Worker 18. Mother's Name	(First Middle A		oital
	land	2 to 2	ToB	William Elmo Jo	ohnson, Sr.			Mary Ca			,
106	Mary	s 1 and 2 should f Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship (7		b. Mailing Ad	dress (Street a	nd Number or Rura			
1/1		item 27		William E. Johnson, 20a. Method of Disposition		320 C	hannel	Rd. Py			
121	Baltimore,	m O		1 Surial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State cemete	ery, cremator,	y`or other place	1144	6.55		City or Town, State
4	altin	permit. Page Department of Important: If any injury or once.	7	21 Shouthing Eure Service Lice				tery 200		hite E enstei	Mall, MD .nMortuary, Inc
	Ö	<u>8</u> 5 6 8	L	Hanes J.	Har-Consteins	£ 19	S. Mai	in St.,	Stewar	tstown	, PA 17363
		Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.	not enter the	mode of dying	, such as cardiac o	respiratory arre	st,	Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death)	a. Due to (or as a consequence b. Due to (or as a consequence	of):	797161	n Janu	ie		21
		Examine	<u>-</u>	Sequentially list conditions,	b. Due to (or as a consequence	470	sho	ck			3 days
V		executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Em	over	na li	ma			
	oʻ	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence	of):		<u> </u>			
	Box 68760	icate br physic s the bu	dicai		d						
	9 x	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy						
	P.O. Bo	Attending Physicien: The law requires that the death certifics radeth. r death. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnancy er (specify)			23d. Date Mon	e of delivery th Day Year
		es that gned t	by P	Part II. Other significant conditions co	entributing to death but not resulting	in the underly	ing cause give	n in Part I.	23e. Did toba	acco use contri	bute to the cause of death?
lian	ord	w requir been si should	ted						1 ☐ Yes	2 No	3 ☐ Probably 4 ☐ Unknown
2,7/	3ec	has b	Completed						24a. Was an autopsy	DI	/ere autopsy findings available rior to completion of cause of
B	a	icien: The lav certificate has rector, page 2		25. Was case referred to medical	38 1000				perform 1 ☐ Yes 2	No 1	eath? □ Yes 2 No
2	>	ysicie is cert directe	To Be	examiner?	Hospital: 1 ☐Inpatient 2 ☐ ER/O	utnatient 3F	DOA Other	26. Place of Death 4 □ Nursing Hom	11 - 25 - 5 - 5 - 5		. (0
NOCH	- - -	ng Ph fter th neral	L:iC	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b.	Time of Injury	28c. Injury Work		Bd. Describe how		
3	Sio	tendi Jeath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be		М	1 🗆 Y	es 2 □No			
10	Division of Vital Records,	itel or Al	Certification:	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)				City or Town,	State)	r or Rural Route Number,
		To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	rsician: To the best of my knowledginer. On the basis of examination ar and manner stated.	e, death occu nd/or investiga	rred at the time ation, in my opi	o, date and place, as nion, death occurre	nd due to the cau d at the time, dat	use(s) and man e and place, ar	ner as stated. nd due to the cause(s)
		With To t	Σ	29b. Signature and title of certifier	0		29c. License				(Month, Day, Year)
	•	. \		Custo	4		000	63420	+	ibul 3	17,2006
		H		30. Name and address of person who con Subair Siddiqi	ompleted cause of death (Item 23a) 500 Upper Ch		ake D	r. Rol 7	ir M	D 210	1 4
		Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		sell D	. Det F	I	υ ΔΙ Ο .	LI
		Registra	31	MAIVO	LUUU NEW MICHES SO	E. C.					

Johnson William

			For State Registrar		partment of Health and Pertificate of Death	Mental Hygien	
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	3. Time of Death
H	Physici /Medic		Woodrow Wilson Jone	S		4	ay Yeer 0845 AM
)	Examin		4a. Fecility Name (If not institution, give s	reet and number)	4b. City, Town, or Location of Deal	th 4	c. County of Death
			Washington County H	lospital	Hagerstown		shington
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Days Hours Min	. (Month, Day, Year	
L	Director		213-18-8744	91 Yrs		June 30, 1	914 Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
	Mary	ğ	Maruland Unahington	Poor about			1 ☐ Yes 2 X No
	28s	Je C	Maryland Washington 10e. Street and Number	Boonsboro	10f. Zip Code	10g. C	Citizen of What Country?
	3a o	Funeral Directo	6408 Old National P	ike	21713	USA	
	deati	ner			Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian,
စ္	after or ite		1 Never Married 2 Married	1 ∑Yes 2 □ No	1 ☐ Yes 2 🖾 No Specify:	to Fican, etc.)	Black, White, etc.
5-0036	uraf',	d by	3 Nidowed 4 Divorced	Year or Dates: WWII			Specify: White
<u>V</u>	within 72 hours after death with the Maryland ane. then "natural", or items 23s or 28s-1 ehow he Modical Exacti her could be codified at	Completed	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation live kind of work done during most of wo	orking 16b.	Kind of Business/Industry
2121	withir ene. then	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)		C . M . C
2	Hygin Hygin Ther	ပို	17. Father's Name (First, Middle, Last)	Asse	mbler 18. Mother's Na	me (First, Middle, Maide	craft Manufacture
an	Mental Mental Arked o	To Be	Vinton Callie Jones		Edith El	izabeth Mar	+ 7
Maryland	2 should be and Mental is marked (sumatic ev	1-	19a. Informant's Name/Relationship (Type	-	ailing Address (Street and Number or R		
	and 2 ealth a n 27 is		Eldon A. Jones, son	13	Della Lane, Boonsb	oro. Marvla	and 21713
altimore,	of He of He fiterr		20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Re	20b. Place of D	sposition (Name of crematory or other place)		Location - City or Town, State
Ĕ	Pages ment of i ent: if its ury or o		4 Donation 5 Other (Specify)		ro Cemetery 4/22	2/2006 Boo	onsboro, Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at ODGe.		21. Sonature of uneral Service License	ө	22. Name and Address of Facility Ba	st Funeral	Home
	ā O ⊑ ē o		Jan M. D	use M00999			
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.	enter the mode of dying, such as cardia	ic or respiratory arrest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Preuminia			Onsot and Douth
	/Medical Examiner		Toolan, and an addition	Due to (or as a consequence of):	· Costidium	dillele)	
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	C - Wolfred C	Marche)	
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A cute Renal	Colostridium C Failure:	//	
c ·	exector and and ital-tra	Еха	resulting in death) Last	Due to (or as a consequence of):			
1760,	The law requires that the death certificate be executed as been signed by the attending physicien and bege 2 should be detached for use as the burial-transit	ical	L _d				
89	leath certifica attending ph I for use as th	Med	IF FEMALE:				
õ	ath ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery
P.O. Box	the all	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
	w requires that the death cer been signed by the attendin should be detached for use		Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I	23e Did tobacco	o use contribute to the cause of death?
Division of Vital Records,	signe d be	d by	Pristate carcer	g are a second part of the second g are a	a and any angle and any and any and any		2 No 3 Probably 4 Dunknown
Ö	v requ been shoul	Completed	Abidominal And	to An usula.		24a. Was an	24h Mara autorou findana austabla
Be	he lav e has	Ę.	19 001100 1700	VI I COUNTY		autopsy performed2	24b Were autopsy findings available prior to completion of cause of death?
ā	in: Ti	ပို	25. Was case referred to medical		00 014 D	1 Yes 2 N	lo 1 Yes 2 No
>	ysicia s cert direct	0 8	avaminar?	ospital:	Other	eath (Check only one) Home 5 Residence	6 Other (Specify)
2	Attending Physician: r death. ector: After this certifice by the funeral director, p	n: T	27. Magner of Death	28a. Date of Injury (Month, Day Yeer) 28b. Tim	e of 28c. Injury at	28d. Describe how inj	
Ö	ath. or: Af	atio	Natural 5 Pending 2 Accident investigation	(World, Day 7007) Illiju	M 1 Yes 2 No		
Ĭ Ž	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	281. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
Ω	olital o urs af ral D						
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, pege	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Madical Examin	er: On the basis of examination and/o	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause(curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	o the ithin (Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	Pate signed (Month, Dey, Year)
	6 1 € 1		N ON TIL	alai	000 62223		/19/06
	2		30. Name and address of person who co	mpleted cause of death (Item 23a) (To		((. 7/08
	5		PLAYEEN BOLA	RUM, MD 340-	MILLSTREET HA	GERSTOWN.	MD 21740.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature			
	Registi	ar	APR 2 0	2006 Bree 15	PO. Print) MILL STLEET, HA		
D1				- C-1101	- J		

		1 - For State Registrar	State of Maryl	and / Depa	artment of F rtificate of	dealth and Death		giene	6	1,122
Physic /Medi		1. Decedent's Name (First, Middle, Last) Claude	Arnold Johr	ison			2. Date of De. Month April	26, 200	O6	3. Time of Death 2:00 A M
Examin		4a. Facility Name (If not institution, give s 22505 Johnson Por	,		4b. City, Town, c	or Location of De		4c. Count	ty of Death Mary	s
Funeral Director		5. Social Security Number 6. Sex 228-07-3546	7. Age (In)	yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Birt (Month, Da March 1,	h y, Year)	9. Birthp	place (State or Foreign htry) Carolina
Maryland -fahow lied at	tor	10a. State 10b. County Maryland St. Mary's		City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the 3a or 28a	il Director	10e. Street and Number 22505 Johnson Pond		JGIII OI II	10f. Zip Code 206	10		10g. Citizen of		
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or Itama 23a or 28a-f ahow Imatic avent, the Marical Examinat must be notified at	by Funeral		12. Was Decedent Ever in Armed Forces? 1 May Yes 2 No If Yes, Give Year or Dates:	'			(Specify Yes or No- erto Rican, etc.)		ace - Americ ack, White,	etc.
Baitimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental hytgiene. mportent: If Item 27 is marked other than "naturel", or nny injury or other traumatic avent, the Modicel Exami	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired fitter	during most of v	warking	16b. Kind of E		dustry
ryland rould be file d Mental H narked oth	To Be	17. Father's Name (First, Middle, Last) William Jefferson				Lula E	lame (First, Middle, Ldwards			
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta importent: If Item 27 is marked any injury or other traumatic avoince.		19a. Informant's Name/Relationship (Typ. Victor L. Johnson / Sc. 20a. Method of Disposition	on 20t	22550	Johnson Pon	d Lane, (Rural Route Numbe	Maryland	20619	
litimol nit. Pages artment of ortent: If it injury or c		1 A Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	rinity Men Gardens	of fal other place	29,	ril 2006 V	Valdorf,		
Deg Teny		23a. Part1. Enter the disease, or common	Hercline Stations that caused he di	Ρ.	U. BOX 2/U	. Leonard	uneral Home, town, Maryla	and ZUbbu		Approximate
Fhysician /Medical Examiner and Examiner as the prival-transit	edicai Examiner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cons	equence of):	distass	7				Interval Between Onset and Death
rs, r.C. box (see that the death certification by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etel death 3 🔲	Ectopic pregnancy Other (specify)				ite of deliver	y Day Year
The law requires that the law requires that the steen signed by the page 2 should be detached.	þ	Part II. Other significant conditions conti	ributing to death but not r	esulting in the un	derlying cause give	on in Part I.				a cause of death?
din Ol VII di neco ding Physician: The law h. After this certificate has b funeral director, page 2 sh	e Completed	25. Was case referred to medical					24a. Was a autops perform	ned? 2⊿No	Were autop prior to com death? 1 ☐ Yes 2	sy findings available pletion of cause of
ysicia ysicia is cert direct	0	examiner?	spital:	☐ ER/Outpatient	3D DOA Othe		eath <i>Check only on</i> Home Reside	*	- 10 1	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	ation: T	27. Manner of Death 1.☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			
oital or Attendurs after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec				28f. Location (St. City or Town	, State)		
To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	cian: To the hest of my k ir: On the basis of examinand manner stated.	nation and/or inve	estigation, in my op	inion, death occ	curred at the time, da	ate and place,	and due to t	the cause(s)
011		29b. Signature and title of certifier	0		29c. License	_	29	9d. Date signed	- /	ay, Year) 2006
m]	30. Name and address of person who com David Tardio, M.D. 110				Frederick	c, Maryland	20678		
Stat Registra	е	31. Date filed (Month, Day, Year) APR 2 7 20	32. Figistrar's Sign		and I		•			

		For	State of Maryla	ind / Dep	artment	of Health and	•	9	. 11.123
		1 - State Registrar		Ce	rtificate	of Death		eg. No.	10160
Physic /Medi		Decedent's Name (First, Middle, Last) CHARLES FIMER KI					2. Date of Dea	16, 200	6 7:15 am
Examir	ner.	4a. Facility Name (If not institution, give s	treet and number)			own, or Location of Deat	h	4c. County of Di	George's
	38	Doctors Hospital 5. Social Security Number 6. Sex	7 Age (In vi	s. last birthday	Lanh If Under 1		. 9 Date of Birth		Birthplace (State or Foreign
Funeral Director			M 2□F 77	Yrs.		Days Hours Min.	8. Date of Birth (Month, Pay 3/27/2	9 ^{Year)} Of	Country)
within 72 hours after deeth with the Maryland ene. then "naturet", or Iteme 23s or 28e-f show the motified at		10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
ours after deeth with the Manylan rei', or iteme 23a or 28e-f show Exeminar mast be notified at	ţċ	Maryland Anne Arun	del Da	vidson	ville				1 ☐ Yes 2 🛣 No
h the	Director	10e. Street and Number			10f. Zip (Code		0g. Citizen of What	Country?
th will	alD	734 W. Central Ave			21	035		Ţ	JSA
eep .	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.		nt of Hispanic Origin? (S y Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Al Black, W	merican Indian,
or it		1 Never Married 2 Married	1 Yes 2 No 19	45-	1 ☐ Yes 2				
72 hours "naturel", olicel Exe	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: W	nite
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ges 1 and 2 should it of Health and Mer if Item 27 is marks or other traumatic		Phyllis Lou Kenney 20a. Method of Disposition		/34 \ . Place of Disp		cral Ave. Da	avidsonvi Date	.11e MD 21 20c. Location - City	
Pages nent of I int: If It iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cre	ematory or oth	er place)			
permit. Page Department Important: If any injury o			the state of the s	alas C		-		Edgewater	
Depa Impo any ir		21. Signatur of Funeral Service License	6.			Address of Facility G			
40260		23a. Parri. Enter the disease, or comples shock, or heart failure. List only on	<i>[/</i>			olomons Isla			MD. 21037 Approximate
Physician data attending physician and attending physician and for use as the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a const	ete.	5	royre			
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tifica ng ph as th	led								
0 0	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	stal death 3	□Ectopic pre □ Other (<i>spe</i>			23d. Date of o Month	delivery Day Year
The law requires that the tte bas been signed by the age 2 should be detache		Part II. Other significant conditions con	tributing to death but not re	esulting in the	underlying ca	use given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
sign d be	d by						1 🗆 Y	es 2 No 3	Probably 4'SUnknown
w require been si should i	ete						04. 146		
has has	Completed						24a. Was a autops perfor	sy prior t	autopsy findings available o completion of cause of
							1 ☐ Yes	2 X No 1□Y	
sicien: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?	ospital:			Othos	ath (Check only or		
Phys this al dir	2	TE TOS ZINO	1/2 Inpatient 2					ence 6 Other (S	oecify)
ing F	o	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury at Work?	28d. Describe h	ow injury occurred	
or Attend frer death frector: / n by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, si	M treet, factory,	1 ☐ Yes 2 ☐ No office	28f. Location (S City, or Tow		Rural Route Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred a	the time, date and place n my opinion, death occu	e, and due to the carred at the time, d	ause(s) and manner ate and place, and c	as stated. ue to the cause(s)
thin the	Med	29b. Signature and title of certifier	and mainter States.		29c	License number	13	9d. Date signed (Mo	onth. Day. Year)
F 3 F 8		- A		perio					•
		Tascom	V			D53718		4-17-	2006
		30. Name and address of person who con				1. M.	20 1101		
State of the state		Thomas Hanssen N 31. Date filed (Month, Day, Year)	32 egistrar's Sig	g LUCK I	load L	anham Md	×0.100		
Sta Regist			06 Jagistians sig	K A	nout !				

Director 15-14-7733 86 975. 2-22-1920 Czecled	ndel place (State or Foreign intry) hoslovakia 10d. Inside City Limits 1 Yes 2 No
Susan M. Koslap Susan M. Koslap	ndel place (State or Foreign intry) hoslovakia 10d. Inside City Limits 1 Yes 2 No
Susan M. Koslap April 10, 2006	ndel place (State or Foreign intry) hoslovakia 10d. Inside City Limits 1 Yes 2 No
Household of Angels S. Social Security Number G. Sex 1	ndel place (State or Foreign intry) hoslovakia 10d. Inside City Limits 1 Yes 2 No
Funeral Director 5. Social Security Number 6. Sex 1 M 2X) F 86 7. Age (In yrs. last birthday) 15. Age (In yrs. last birthday) 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. 18. Date of 8irth (Month, Day, Year) 2-22-1920 CZecl Waryland Anne Arundel 10c. City, Town or Location Maryland Anne Arundel 10d. Street and Number 10f. Zip Code 10g. Citizen of What County 10d. City Town or Location 10d. Zip Code 10d. Citizen of What County 11d. Marital Status 11d. Naried Status 11d. Marital Status 11d. Naried	hoslovakia 10d. finside City Limits 1 Yes 2 No
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To a State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What County 809 Coxswain Way 21401 11. Marital Status 12. Was Decedent Ever in U.S. A med Forces? 11. Dispers Maried 21 Maried 1. Dispers Maried 22 Maried 1. Dispers Maried 22 Maried 1. Dispers Maried 23 Maried 1. Dispers Maried 24 Maried 1. Dispers Maried 25 Maried 1. Dispers Maried 26 Maried 1. Dispers Maried 1. Dispers Maried 26 Maried 1. Dispers Maried 27 Maried 27 Maried 1. Dispers Maried 27 Maried 1. Dispers Maried 28 Maried 1. Dispers Maried 28 Maried 1. Dispers Maried 28 Maried 1. Dispers Maried 1. Dispers Maried 28 Maried 1. Dispers Maried 1	1 ☐ Yes 2 X No
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10e. Street and Number 809 Coxswain Way 11. Marital Status 1	intry?
809 Coxswain Way 1. Marital Status Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working in the property of th	
Amed Forces? Amed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Slack, White, Specify: What Specify:	ican Indian,
The state of the s	, etc. nite
15. Decedent's Education 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	
	ndustry
Cofflege (1-4or 5+) Relementary/Secondary (0-12) Sth Assembler Wire and Cofflege (1-4or 5+)	able Co.
N 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
Description of the property of	in Code)
Andrew Minnak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig. Maria S. Mark/ Niece 809 Coxswain Way, Annapolis, MD 21401 20a. Method of Disposition 1 Buriaf 2 Cremation 3 MRemoval from State 10 Buriaf 2 Cremation 3 MRemoval from State	p C000)
Maria S. Mark/ Niece 809 Coxswain Way, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To	own, State
E d b d Donation 5 Other (Specify) Mt. Hope Cemetery 4-10-00 Hastings-on-	
21. Signature of Funeral Bervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Service Licensee 23. Solomons Tsland Rd. Edgewater Miles	
2973 Solomons Island Rd. Edgewater, M	Approximate
shock or heart failure. List only one cause on each line.	Interval 8etween Onset and Death
/Medical resulting in death) Due to (gras a consequence of):	Lyeurs
Examiner	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
for any, leading to immediate cause. Enter Underflying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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d. Comparison of the position of the positi	
So S	very Day Year
in the past 12 poinths? Comparison of the past 12 poinths? 1 1 1 1 1 1 1 1 1	
Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contribute to the s	
So	
TO TO TO THE TO TO THE	opsy findings available ompletion of cause of
The state of the s	2 No
25. Was case referred to medical examiner? 1	111111111111111111111111111111111111111
O to	1
O To the control of t	ral Route Number,
27. Manner of Death 28a. Date of Injury 28b. Imme of Injury at 1 Natural 28b. Injury at 1 Now injury occurred 28c. Injury at 28c. Injury at 28c. Injury at 28c. Injury at 3 Now injury occurred 28c. Injury at 3 Now injury occurred 28c. Injury at 3 Now injury occurred 28c. Injury at 3 Now injury at 28c. Injury at 3 Now injury occurred 28c. Injury at 4 Now injury occurred 28c. Injur	
2 2 2 9	stated. to the cause(s)
29a. Certifier Control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a second of the cause (s) and manner as second of	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a control of the cause	
## 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	006
30. Name and address of person who completed causes death (Item 23a) (Type, Print) Paul F. Berrez M.D.	006
1 oul Bern MD 13 00 29571 04/18/20	006

			1- For Amend Items 23b, 25, per ME, 6856, 06/14/06dho 1- Registrar 1- Registrar	lental Hy	giene Reg. No: 006	14125
	Physicia	20	Decedent's Name (First, Middle, Last)	2. Date of De	Day Vace	3. Time of Death
	/Medic	al .	Laura H. Kabler 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	7.00A M
1	Examin	er .	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BATTMOPEWAS HTNGTON MEDICAL CENTEL CLEN BURY 15 Linder 18 August 16 Linder 18 August 16 Linder 18 August 16 Linder 18 August 17 Linder 24 Hrs.		ANNE	Agenine
	Funeral		5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) iii Olider 1 feat iii Olider 24 his	8. Date of Bir (Month, Da	th 9. Bir	thplace (State or Foreign ountry)
	Director		206-01-5749 94 Yrs.	May 19	, 1911 Pen	nsylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	tor	Maryland Anne Arundel Odenton			1X Yes 2 □ No
	ith the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	ath w	rai	8735 Piney Orchard Lane 21113	and Van as Na	USA 14. Race - Am	ociona Indian
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Rican, etc.)	Black, Whi	
93	72 hours after death with the Maryland natural; or Itema 23e or 28e-f show dical Examinar must be notified at	by	3 Modowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify:		Specify:	hite
2-0	natur cical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business	s/Industry
121	within ene. then "	dmc	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker		State of	Virginia
d 2	other	0		e (First, Middle	, Maiden Sumame)	
/lar	should be and Mental le marked o	To B	Alfred Q. Hamilton Olive Al	llen		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type, Print) Priscilla Cressman / Niece 308 Cedar Lane, Annapo			Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Menth Hygiens. If Item 27 is marked other than "natural", or items 23s or 28s-f show it Item 27 is marked other than "natural", or items arrunal be notified at or other traumatic event. The Madical Examinal must be notified at		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City of	r Town, State
Baltimore,	Pages nent of I ant: If Its ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mullins & Thompson 4/20	/2006	Stafford,	VA
aĦ	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility RC			2721412
<u>m</u>	20529		16000 Annapolis Ro			T
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	/		
	Examiner		Etiology unknown			
	D ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Into CALF	XAMINE	
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	ED BY MED.		
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89	tificate ig phys as the					
Вох	eath certificat attending phy I for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy		23d. Date of de Month	elivery Day Year
-	the d	Physician/Med	in the past 12 months? 1 Yes 2 2No 9 Unknown 9 Unknown		, inchar	bay tour
P.0	res that thigned by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Records,	quires n sign uld be	ed by		10	Yes 2 □ No 3 □ F	robably 4 Sunknown
000	aw requir as been si 2 should I	Completed		24a. Was	psy / prior to	autopsy findings available completion of cause of
æ		Com		perfo 1 ☐ Yes	ormed?/ death?	
Vital	Phyalcian: this certificanal director, I	Be	25. Was case referred to medical examiner? Hospital: Other: Other:			
ō	> .∞ 0	To It			idence 6 Other (Sp	ecify)
jon	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Pes 2 No			
Division	r Atte	rtific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or F wn, State)	Rural Route Number,
a	pital o	Se	29a. Certifier 19 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place.	and due to the	cause/s) and manner	as stated
	To the Hospital or Attending Phwithn 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification;	(Check only one)			
	To th within To th comp	Me			29d. Date signed (Mor	nth, Day, Year)
) 5.42 MD D.42(46		13 PN 13	, 2006
_				DWMC	mo s	2061
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 7 2006 Registrar's Signature			

AA.Ch #33a

				Obets of Manden	4/5-		1 - 141			
			For	State of Marylan				Mental Hygie	ene	11100
			1 - State Registrar	4-2	Ce.	rtificate of I	Death		No. UUD	14/60
	Dharist		1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Esther Kessler					April 14		2:00 A ^M
w Vice	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of De		4c. County of Death	
			Potomac Valley N	Jursing Home		Rockvi	1116		Montgom	0 7 37
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs. I	last birthday)	if Under 1 Year	If Under 24 H	rs. 8. Date of Birth	9. Birth	nplace (State or Foreign untry)
	Director		089-03-4753	□M 2XF 89	Yrs.	Months Days	Hours M	in. (Month, Day, Y Dec 6, 1		York
	D		Usual Residence of Decedent					1200 0, -	7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 -	2 2 2 2 2
	ylan how		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	Ma-f-s	50	Maryland Montgo	merv Be	thesda					TXTYes 2 ☐ No
	n 158	ire	10e. Street and Number	23.0		10f. Zip Code		10g	. Citizen of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be rigitled at	<u>و</u>	6913 Ayr Ln			20817	7		USA	
	deat ms	Funeral		12. Was Decedent Ever in U.	S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race - Amer	
ယ	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No				erto Hican, etc.)	Black, White	e, etc.
ğ	urs a al', o Exan	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	hite
21215-0036	2 ho	Completed by	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business/l	ndustry
돐	nn 7 nn 7 Med	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	dunng most or v d)	vorking		
2	d wit	ПО	12	Sologo (1 lor o 1)	Ski	p Tracer			Collec	tions
ਕੂ	othe	e C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, Ma		
ā	lid by	E	Harry Schild				Mo11s	Greenberg		
Maryland	shound M	_	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street		Rural Route Number, C		ip Code)
ž	ith a	- 1	Janet F. Waxman/	Daughtor	6	013 Axx T	n Dott	esda, MD 2	0017	
ē,	Hea Hea tem	1	20a. Method of Disposition	20b. P	face of Dispo	sition (Name of			c. Location - City or	Fown, State
Baltimore,	Por in age		1 XBurial 2 Cremation 3 P	removal from State	-	matory`or other plac	.			E .
ቜ	rit P	1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens	1 2 41		View Cem	Ap1	18, 2006	Newport	. CA
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event. The Medical Examination must be notified at once.		21. Signature of Contract Service Electric					nes-Rinald		
			22a Parti Fater the disease of small	iontions that anyone the death						2, MD 20904
	153		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ne cause on each line.	i. Do not em	er the mode or dyin	ig, such as card	iac or respiratory arrest	1	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	aLU	ng	can	er			1 year
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uerroof):					V
П	xaminio	_	Sequentially list conditions,	b						
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
	ecute and trans	Examiner	that initiated events resulting in death) Last	3						
1760,	te be executed ysician and le burial-transit	ω		Due to (or as a consequ	zence or):					
876		lcal		J						
89)	artific ing p e as	Mec	IF FEMALE:							
Box	th ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	,		23d. Date of deliment	very Day Year
o.	e dez	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	eath 5[Other (specify)			World	Day real
<u>.</u>	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as the	by Physiclan/Med	9 Unknown							
	gnec be de	by	Part II. Other significant conditions cor	A no	ulting in the u	nderlying cause givi	en in Part I.		cco use contribute to	
Records,	w require been si should b	bed	Dene	itia				1 LJ Yes	2 No 3 Pro	bably 4 Unknown
Š	e law n has be je 2 sh	ple	Stroke	(24a. Was an autopsy		topsy findings available ompletion of cause of
	The cate has page	Completed						performed	d? death?	2 No
Vital		0	25. Was case referred to medical				26. Place of D	eath (Check only one)	70	
	Attending Physician: r death. ector: After this certific. by the funeral director.	0 8	examiner? 1 ☐ Yes 2 🗷 🗓 Yo	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier	nt 3 DOA Cthe	er: 4 Vursino	Home 5 Residence	e 6 Other (Spec	rify)
o	g Ph er th eral	L I	27. Manner of Death	28a. Date of Injury	28b. Time o		y at	28d. Describe how		,
0	ndin th. :: Aft	att o	Natural 5 Pending investigation	(Month, Day Year)	Injury	M 1 🗀	vr Yes 2 □ No			
Division	deg deg	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, farm, sti	reet, factory, office		28f. Location (Street	at and Number or Ru	ral Route Number,
0	4 - 8 6	T	4 ☐ Homicide determined	building, etc. (Specify	/)			City or Town, S	otate)	
	after death after death Director: d in by the	0		111	wied de, deat			ice and due to the caus	se(s) and manner as	
	spital or A	al Ce	29a. Certifier Certifying Phys	sician: To the best of my know		h occurred at the tirr	ne, date and pla	ico, and due to the caus		stated.
	Hospital or 4 hours afte Funeral Dir ely filled in	dical Ce	29a. Certifier Certifying Physical (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	curred at the time, date	and place, and due	stated. to the cause(s)
	Hospital or 4 hours afte Funeral Dir ely filled in	Medical Ce	(Check only 2 Medical Exami	ner: On the basis of examinat	tion and/or in	h occurred at the tim vestigation, in my of 29c. License	pinion, death oc	curred at the time, date	and place, and due Date signed (Month	to the cause(s)
ŀ	afte Dir	edical	(Check only 2 Medical Examination)	ner: On the basis of examinat	tion and/or in	vestigation, in my of	pinion, death oc	curred at the time, date	and place, and due	to the cause(s)
	Hospital or 4 hours afte Funeral Dir ely filled in	edical	(Check only one) 29b. Signature and title of certifier	ner: On the basis of examinat and manner stated.	tion and/or in	29c. License	pinion, death oc	curred at the time, date	and place, and due	to the cause(s)
ŀ	Hospital or 4 hours afte Funeral Dir ely filled in	edical	(Check only 2 Medical Examination)	ner: On the basis of examinat and manner stated.	(2) (Type,	29c. License Print)	pinion, death oc	curred at the time, date	and place, and due Date signed (Month	to the cause(s)
	Hospital or 4 hours afte Funeral Dir ely filled in	Medical	29b. Signature and title of certifier 30. Name and address of person who co	ompleted cause of death (Item	(2) (Type,	29c. License	pinion, death oc	curred at the time, date	and place, and due Date signed (Month	to the cause(s)

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of Mary		artmen rtificat			and M		giene Reg. No.	006	14/28
		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
Physici /Medi		Leola Gertr	rude La	iwson					Month April 17	Day 200		10:00 A M
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location o	of Death	************		County of De	ath
		Forestville Health & H	Rehab. Center		Fores	stvill	e			Pr	ince Ge	orge's
Funeral		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birt	h	9. B	irthplace (State or Foreign
Director		210 14 3713	JM 2017 8	8 Yrs.	101011110	Days	110013		June 9,	1917		Maryland
pu »		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation							10d. Inside City Limits
anyla shov	7											1 Yes 2XX No
98a-f	ctc	Maryland Prince (eorge's	Cheltenha	_							
vith ti	급	100. Street and Number 10001 Behun Drive			10f. Zip	Code 0623				_	zen of What (USA	Country?
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland no Mental Hyglene. marked other than "natural" or Items 23s or 28s-1 show marked other than "natural" or Items 23s or 28s-1 show marked other than Maryland at marker halfied at the Maryland at	by Funeral Director		10.1% - D 1 1 C	:- 110			-1.0	:-0.10	7 1/ 1/			- i - a tadian
er de Item	une	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Deced	of His	spanic Orig n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, Wh	nerican Indian, nite, etc.
hours aft	y F	1 Never Married 2 Married 3 Widowed 4XXXXvorced	1 ☐ Yes 2 KN No If Yes, Give Year or Dates:		1 🗆 Yes	2XXNo	Specify:				Specify: V	White
hou		15. Decedent's Edu		16a. Dece	dent's Usua	al Occupa	ition			16b. Kii	nd of Busines	s/Industry
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iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Clei	rk					P.G.	County	Government
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d be fill be contact by the contact be fill be	To B	Joseph W. Allen					Sele	ena O	ırry			
Id yidilid ZIZIOOOOO 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Examir or must be notified at	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	al Route Numbe	r, City or	Town, State,	, Zip Code)
IVIC nd 2 lith a 27 is r trat		Sandra Elaine Linder /	Grandaughter	10001	l Behur	Driv	e Chel	tenha	m, Maryla	and	20623	
s 1 a g		20a. Method of Disposition	20	Ob. Place of Dispo	sition (Nar	ne of	1		Date		cation - City of	or Town, State
age age wit: #		1 Burial 2 □ Cremation 3 □ F 14 □ Donation _y 5 □ Other (Specify)		akemont Ce	emetery	ины ріасе Т	" O	4/20/	/2006	Davi	dsonvill	le, Maryland
Defittingley, Wall yilding Z.I.Z.13-00030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Juneral Service Licens		22	2. Name an	d Addres	s of Facility	laara	D P K	120	Funor	al Home PA
Department of the part of the		Ilm F.	Koles									MD. 21037
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w requires I been signe should be	d b								1 🗆 Y	es 2[□No 3□F	Probably 4 Unknown
w requires that been signed to should be det	lete								24a. Was	an	24b. Were	autopsy findings available
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vital ician: T sertificat ector, pa	ပိ	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	2XXV0	1 🗆 Y €	es 2 No
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ding Phys	H- 1	27. Manner of Death	28a. Date of Injury (Month, Day Yea			8c. Injury Work			28d. Describe h			ocity)
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lor Attending after death. Director: After in by the fune	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, str	reet, factory	, office		1				Rural Route Number,
din b	Certification;	4 Homicide	building, etc. (Sp	овсіту)					City or Tow	n, State)		
spits nours neral		29a. Certifier	sician: To the best of my	knowledge, deat	h occurred	at the tim	e, date and	d place, a	and due to the o	ause(s)	and manner	as stated.
To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical	(Check only 2 Medical Exeminate)	ner: On the basis of examend manner stated.	mination and/or in	vestigation	, in my op	inion, deat	th occurr	ed at the time, o	date and	place, and du	ue to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	\wedge		290	. License						nth, Day, Year)
		· Munu	49)		-	5	1520			04.	-17-	06
		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print)							
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Regist	_	APR 197	2006	JO A	DB OFF							

			1 → For State Registrar	State of Mary		artment of H			giene U6	14/29
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Year	3. Time of Death
ı	Physici /Medic		J	ohn Eugene	Levering	I		April	20 2006	1:40 A M
	Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of Dea	th	4c. County of Dea	th
			Glen Meadows			Glen A			Baltim	
	Funeral		5. Social Security Number 6. Sex	M 2 T F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da)	h 9. Bir	thplace (State or Foreign ountry)
	Director		226 18 2526 Usual Residence of Decedent	83	115.			Sept 2	8,1922 Ma	ryland
	land		10a. State 10b. County	100	c. City, Town or Lo	ocation			17.00	10d. Inside City Limits
	Mary f sh	ō	MD Baltimor	_	N					1 ☐ Yes 3€ No
	28a	Director	MD Baltimor 10e. Street and Number	e i i	Phoenix	10f. Zip Code			10g. Citizen of What Co	ountry?
	3a o		3913 Longmoor Circ	1 e		2113	1		United Sta	atas
	ms 2	Funerai		2. Was Decedent Ever	in U.S. 13.	Was Decedent of H		Specify Yes or No-		ncan Indian,
ထွ	after or tte	F.	1 Never Married 2 Married	Amed Forces? 1 A Yes 2 □ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	no nican, etc.)		e, etc.
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2	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or items 23a or 28a-f show event, the Mccisal Examinal must be motified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup- kind of work done of	during most of wo	orking	16b. Kind of Business	/Industry
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au		8	Thomas Alexander L	everina			Mamie W		,	
Maryland	should be nd Menta markad umatic ev	유	19a. Informant's Name/Relationship (Typ		19b. Mailii	na Address (Street a			or, City or Town, State,	Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Susan Streckfus/Nic						MD 21131	,
ō,	of Heal		20a. Method of Disposition	20	0b. Place of Dispo	osition (Name of matory or other place	(a)	Date	20c. Location - City or	Town, State
Ë			Male Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)			Park Cem		5-2006	Baltimore	, MD
altimore,	그 는 글 글		21. Signature of Funeral Service License	e and MC	1044 2	2. Name and Addres		the second secon		nily FH Inc.
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	9 4 9	Completed by						perfor	med? death?	
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0	ding Ph h. After th funeral		27. My ne of Death 1 Latural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Worl		28d. Describe h	ow injury occurred	
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Division of	i or Atten after deat Diractor: I in by the	Certification:	4 Homicide determined	28e. Płace of Injury - building, etc. (S)		eet, factory, office		28f. Location (S City or Tow	Street and Number or Ri m, State)	ural Route Number,
	Hospital or Attending Physician: 44 hours after death. Funeral Directors (Aler this certific tely filled in by the funeral director.		29a. Certifier Detrifying Physic	iniana To the heat of my	, knowledge, deat	h account at the time				
	To the Hospital within 24 hours a To the Funeral C completely filled	edical		ician: To the best of my er: On the basis of exa and manner stated.	mination and/or in	n occurred at the tin vestigation, in my of	ne, date and plac pinion, death occ	e, and due to the d urred at the time, d	cause(s) and manner as date and place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	MIN		29c, License	e number.		29d. Date signed (Mont	h, Day, Year)
	- s - ō		> MWXMI	h		1) 30	1433		Aml 29,	2006
Fn	100		30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type.	Print)	51-	1 11-	HAML 20,	4 2/20/
	(60)		MALY MO GO	3MC 67	0/ N	Charle,	1 70	mulin	upre M	N 21204
	Sta Registr	+	31. Date filed (Month, Day, Year)	32. Refristrar's S	Signature	Armall 6				

			1 - For Stata Registrar	State of Marylai	nd / Depa		t of H	ealth an	d Me	ntal Hygi	ene	96	14130
	Physic /Medi	cal	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give	Grace Lei	ls	4h City	Town or	Location of D		Date of Death Month イネタッ	Day 25	Year 7006	3. Time of Death
	Exami	ner	14549 National P:	ike ex 7. Age (In yrs.	last birthday)	Clea If Under	r Sp	ring If Under 24		Date of Birth	Was	hingt	On place (State or Foreign
Ŀ	Director		217-58-3698 1	□ M 20Å,F 56	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, 1 Jan • 19	1950	Pen	Ina .
	with the Ma 3a or 28a-f s	Funeral Director	MD. Washing 10e. Street and Number 14549 National P:		Clear	10f. Zip				109	g. Citizen o	f What Cour	1 □ Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-1 show many injury or other traumatic event, the Madical Examinar must be troubled at ance.	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:			ent of His	spanic Origin' i, Mexican, P Specify:	? (Specifi verto Ric	y Yes or No- an, etc.)	14. Ra	ace - Americ lack, White,	
Maryland 21215-0036	id within 72 ho giene. er than "natur i, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us Home:	k doné di e retired)	uring most of	working	16		Business/Ind	dustry
ryland	should be file nd Mental Hy marked othe imatic event	To Be (17. Father's Name (First, Middle, Last) Norman A 19a. Informant's Name/Relationship (7	A. Halteman	19b Mailir	ng Address		Vi	ola l	irst, Middle, Ma Mae Hed oute Number, (rich		a Code)
ore, Ma	iges 1 and 2 sold of Health art if itam 27 is or other trau		Glen D. Leis/Hus 20a. Method of Disposition 1 Burial 2	Sband 20b. I Removal from State		9 Nat:	iona:	l Pike		ar Spri	ng, M	d. 21	722
Baltimore,	permit. Po Departme Important any injury once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Z. Chu	rch Cei	meter: 2. Name and	V d Address	of Facility		neral H			7225
760, <	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	quence of):								Approximate Interval Between Onset and Death
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Δ.	The law requires that the site has been signed by the bage 2 should be detache	Completed by Ph	Part II. Other significant conditions co	ontributing to death but not res	sulting in the ur	nderlying ca	use giver	n in Part I.	_		2 400	3 🗌 Prob	ne cause of death? ably 4 □Unknown
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Div	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edical Certif	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specifican: To the best of my known iner: On the basis of examina	y) wiedge, death	1 occurred a	it the time	o, date and pl	ace and	due to the cau	State)	anner as st	I Route Number,
)	To the H within 24 To the F complete	Medi	29b. Signature and the of certifier	and manner stated.		29c	License	number		294	Date sign	ed (Month I	Day Vaari
8 1	i) Sta	te 🐇	30. Name and address of person who come for the second of	completed cause of death (Item 19,0 (I		Print	NEC	L Ro	ad	Hasu	'stow)	n, lt	21742
	Registr	ar	MAY 0.3	2006	K A	market	7 , 1						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Avonne Fay Lambert 04 28 2006 /Medical 12.05 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany 9. Birmplace (State or Foreign St. Vincent DePaul Nursing Center Frostburg MD 8. Date of Birth (Month, Day,) Aug 28, **Funeral** Days Hours 1 M 2 KF 235-96-9689 Director 63 ΜD Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location 27 is marked other then "neturel", or Items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at MD Allegany LaVale 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 South First Street 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other then 1 any injury or other treumatic event, the Means. Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Amos Lambert Mildred Dyre (Nelson) Lambert ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Ganoe 674 Gravel Hill Road sister Frostburg MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Sunset Memorial Park 5/1/2006 * 4 ☐ Donation 5 ☐ Other (Specify) MD Cumberland 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 th. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colitis **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Dav 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 21 No 1 Tyes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check onlone Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours at the Funerel Dietely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58853 28

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAY 0 3 2006 Jen & South

ORIGINAL

131 PENNSYL VANIA AVE, CUMBERLAND

MD 21502

CHOTANI

			For State Registrar	State of M	aryland / Dep		nt of H	ealth a	and M		_	16	14132
	Physic	010	1. Decedent's Name (First, Middle, La	ist)		9/				2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		Florence I. Law						(04/14/20		1001	10:15 A ^M
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			4912 Riverton L		de la laction de) If I lade	Bowi r 1 Year		O.4 Han		Prin		eorges
-	Funeral Director			1 M 2 X F	ge (In yrs. last birthday 83 Yrs.	Months		If Under Hours		8. Date of Birth (Month, Day) May 22,1	922	9. Birthp Cour NY	lace (State or Foreign ntry)
	/land		10a. State 10b. County		10c. City, Town or L	ocation						1	Od. Inside City Limits
	Man 3-f sh	to	NY Steub	en	Cornin	ıg							1 X Yes 2 □ No
	th the	Funeral Director	10e. Street and Number			10f. Zip	o Code			10	g. Citizen of	What Cour	ntry?
	th will	a	101 Columbia Av	e. Apt#41	3	1	4830				USA		
	r des	ne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sper	cify Yes or No- Rican, etc.)		ce - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣	No	1 🗆 Yes		Specify:		,,		v: Whi	
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Ď	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Madical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, Ma			
/lar	Menta Menta arked atic ev	To E	Charles We	lshans				Ma	bel E	Robinson			
Maryland 21215-0036	s 1 and 2 should f Health and Men itam 27 ie marke other traumatic		19a. Informant's Name/Relationship			ing Address	s (Street a	ind Numbe	r or Rural	Route Number,	City or Town	, State, Zip	Code)
	and ealth m 27		Bonnie L. Lawre	nce/ Daugh		2 Riv		n Lan		owie, MD	2071	.5	
Baltimore,	Pages 1 a nent of Hea int: if itam iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [Removal from State	20b. Place of Disp cemetery, cre	matory or c	other place				c. Location		
Ë	tmen tant:		4 ☐ Donation 5 ☐ Other (Speci	(y)	Hope Ce		-		-	L 19,200		ning,	
Bal	permit. Pages Depertment of I important: If its any injury or of		21. Signature of Funeral Service Lice	nsee	2	2. Name ar 16000	nd Addres Anna	s of Facility apoli	^y Robe s Roa	ert E. E	vans F e, MD	unera 2071	1 Home 5
			 Part 1. Enter the disease, or com shock, or heart failure. List only 	plications that caused one cause on each li	the death. Do not en ne.	iter the mod	de of dying	, such as	cardiac or	respiratory arres	t,		Approximate Interval Between
	Physician '		Immediate Cause (Final disease or condition	_ a. (Consostive	Her	and	FA	lure				Onset and Death
- 35	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	^		^					
	1. ***	-	Sequentially list conditions,	b. Due to (or as	a consequence of):	H	ntery	13	<i>Lsean</i>	-			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or,								
	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						-		
8760,	ate be executed hysicien and the burial-transit	cal	· ·	d									
9	uficati g phy as the	edic		3									
Вох	death certific e attending pl ed for use as t	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pi					23d. Da	ite of delive	ry
Θ.	deat death	sicie	in the past 12 months?	4☐Pregnant at	_	Other (sp					Mo	onth	Day Year
P. O.	at the	Physician/Med	9 Unknown										
	res that the de signed by the a i be detached f	by	Part II. Other significant conditions	1	1	ſ		n in Part I.			\ /		e cause of death?
ord	w require been signations of the state of th	Completed	dimberes, mype	chensia,	hypulipi	TEMIN 3				1 🗆 Yes	2 X No	3 Prob	ably 4 Unknown
ec	e law	nple								24a. Was an autopsy		Were autor	osy findings available inpletion of cause of
<u> </u>	: The	ပိ								performe 1 Yes 2	No No	death? 1 □ Yes	2 🗆 No
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the tail director, page 2 should be delached.	Be	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only one)			Daughter's
of	Phys this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie			Othe 28c. Injury	4 🗆 1901		e 5 Residence			Home
OU	ding h. After tune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Injury	M	Work	? es 2 □ N		DG. Describe now	injury occur	190	
/ISI	Attending ir death. actor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b	e 200 Place of Inc	ury - At home, farm, st					8f. Location (Stre	et and Numb	oer or Rura	Route Number
2	efter Dira d in b	ert	4 Homicide determined	building, et	c. (Specify)		,			City or Town,			riodio riambol,
	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying F(Check only one)	nysician: To the best niner: On the basis of and manner sta	of my knowledge, deat f examination and/or in	th occurred evestigation	at the time, in my op	e, date and inion, deat	d place, ar h occurred	nd due to the cau d at the time, date	se(s) and ma and place,	anner as stand	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie			290	. License	number		290	. Date signe	d (Month, L	Day, Year)
	->-0		1.10	eu iw		1	2898	9			_	1-06	
			30. Name and address of person who		eath (Item 23a) (Type.		1000	1			4 1	i ve	
			Jeffrey Hoeck, M.		4175 N. Han		Ct#20	3A Bo	owie,	MD 2071	.6		
9	Sta		31. Date filed (Month, Day, Year)	32. Pygistr	ar's Signature	1							
	Registr	ar	APR 17	2006	- 16	hart							

		For State Registrar	State of Ivia	iryianu		rtificate of		Wellal Hy	Reg. No.	006	14133
Physicia		Decedent's Name (First, Middle,	Last)					2. Date of De	aath Day	Year	3. Time of Death
Physicia /Medic		THOMAS	EDWARD	LAS	STER			Apri1	17,	2006	10:00 P M
Examin	er	4a. Fecility Name (If not institution,				· ·	or Location of Dea	ath	112	County of Death	
		Shady Grove 5. Social Security Number		ospita e (In yrs. las		Roo	ckville If Under 24 Hr	S. 8 Date of Riv		ntgomer	4
Funeral Director		219–38–7140	1 ∑ M 2□F	63	Yrs.	Months Days			7, 19	42 Tenr	place (State or Foreign ntry) Lessee
ъ		Usual Residence of Decedent									
how	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 X No
88-f	Directo		gomery		Rock	ville					
with the	Dire	10e. Street and Number				10f. Zip Code	0050		-	zen of What Cou	
eath v	Funerai	13757 Travi1	ah Road 12. Was Decedent E	Ever in IIS	13 1		0850	Specify Ves or N		ted St	ates
fter d	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 🕱 N					Specify Yes or No erto Rican, etc.)		Black, White	
al', o	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🗶 No	Specify:			Specify: Wh	ite
72 ho	Completed	15. Decedent' (Specify only highest	Education grade completed)		16a. Dece	dent's Usual Occu	pation during most of w	orkina	16b. Kir	nd of Business/Ir	ndustry
ithin han	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of w ad)	•			£
iled w Hygier Iher ti		12 17. Father's Name (First, Middle, L	ast)		ra	rmer	18 Mather's Na	ame (First, Middle	Maiden	Surrame)	farming
d be f intal h	Be C	Haskill	431/	Last	- 0 -						
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In a Mental Hygiene. In marked other than "netural" or iteme 23a or 28a-f ehow umatic event, the Moulcal Examinant months in notified.	_C	19a. Informant's Name/Relationsh	p (Type, Print)	Барі		ng Address (Stree	Ida t and Number or F	Louise Rural Route Numb		anis r Town, State, Zi	p Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menlar Hydiene. Department of Health and Menlar Hydiene. Propriet Traumatic event, the Menlar Examinational be notified at annex.		Robert Wesley L	_		2735	Chestn	ıt Grove	Rd./ Kee	edvsv	ille. M	21756
other other		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other pla	1	Date		cation - City or T	
Pages nent of int: If it		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Sp				Cremato		i1,24,06	Fred	erick,M	arvland
permit. Departn Imports eny inju		21. Signature of Funeral Service L	icensee /) 22	. Name and Addr	ess of Facility	Stauffer			
8258		Baymone	Weles	in	/ 1	621 Opos	sumtown	Pike/ Fr	eder	ick, MD	21702
		23a. Part1. Forer the disease, or of shock, or heart failure. List of	complications that caused nly one cause on each lin	the death.	Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory a	arrest,	- 1	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_ a	Sep	sis						24 hours
/Medical Examiner		resulting in death)	Due to (or as a	a c <i>o</i> nseque	nce ol):						
	er	Sequentially list conditions,	b. Due to (or as a	a conseque	nce ol):						
petr Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(,							
tificate be executed g physicien and as the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	a c <i>o</i> nseque	nce of):						
ysicie	edicai		d								
ه ح ت ت	_	IF FEMALE:									
eath cert attending	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome a 1 ☐ Live birth			Ectopic pregnanc	;y		2	23d. Date of deliver Month	rery Day Year
at the dea by the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ith 5□	Other (specify)				World	Suy Tour
that the ed by		Part II. Other significant condition	Is contributing to death bu	ut not result	ing in the u	nderlying cause g	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
signe d be	d by		ith gastric			,,		10	Yes 2	□No 3□Pro	bably 4 XUnknown
w requir been si should	Completed	Duodemitis						24a. Was	s an	24h Ware aut	opsy findings available
The lav	ш	DUOUCIITETS						auto perf	omed?	prior to co	ompletion of cause of
iclan: Th	e C	25. Was case referred to medical	<u> </u>				26 Place of D	1 ☐ Yes eath (Check only	2 No	1 🗆 Yes	2 ∐ No
ysicla s cert direct	.0 B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatie	nt 2 El	R/Outpatier	nt 3□ DOA O	hor	Home 5 ☐ Res		3 □Other (Spec	fy)
ding Physiclan: h. After this certific funeral director,	n: T	27. Manner of Death	28a. Date of Injur (Month, Day		8b. Time o	28c. Inju		28d. Describe			
tendir Jeath. tor: Af the fur	atic	1 ØNatural 5 ☐ Pending 2 ☐ Accident investig.	ation		,-,]Yes 2□No				
al or Att efter d I Direct d in by t	Certification:	3 Suicide 6 Could n 4 Homicide determi		ury - At hom c. (Specify)	e, larm, str	eet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rui)	al Route Number,
To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	edical (29a. Certifier 1 X Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examinatio	edge, deatl on and/or in	h occurred at the t vestigation, in my	me, date and place opinion, death oc	ce, and due to the curred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
To th To th comp	Me	29b. Signature and title of denifier		-	1110	29c. Licen	se number		29d. Date	e signed (Month	Day, Year)
		1 XX			44	D !	58681		Apr	il 18,	2006
3		30. Name and address of person v				Print) Shad	dy Grove	Adventi	st Ho	spital	
1		/ Jude A	lexander, M) / 99	901 Me	edical Co	enter Dr.	./ Rockv	ille,	MD 2	0850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2006

been & food

		•	1 - For Stete Registrar	State of M		d / Depa	artment		th and		-	000	4 3 4
//\	ysicia ledic amin	al -	Decedent's Name (First, Middle, Other State of the Control of the Contr	Qive street and number	ar)	ĺ		LFF (AP	21 10	Year	Q 430 AM
Fun Dire	eral		5. Social Security Number 6	Sex 1 M 2 F 7.		last birthday) Yrs.	If Under Months	1 Year If U	nder 24 Hrs urs Min.	. (Mc	te of Birth onth, Day, Yea	9. Bi	ountry)
ne Maryland 8a-f show	तारिक्ट वर	ctor	Usual Residence of Decedent 10a. State 10b. County MD Harfor	d		y, Town or Lo Aberde	en						10d. Inside City Limits 1 □XYes 2 □ No
Dattillore, Mary Jiallo, 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show	Examinat must be re	by Funeral Director	10e. Street and Number 450 Bernice Ter 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force	s? ∑INo			21001 ent of Hispan fy Cuban, Me	ic Origin? (S xican, Puer ecify:	Specify Ye rto Rican,		USA 14. Race - Am Black, Wh Specify: WI	erican Indian, ite, etc.
ed within 72 ho ygiene.	t, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4d	or 5+)	16a. Deced (Give life.	kind of worl DO NOT us	Occupation k done during e retired)			B L	Kind of Busines: rooklyn ibrary	,
y idilu	natic evan	To Be	17. Father's Name (First, Middle, La Ralph Sica			10b Maille	- Add		Marga	ret C	Middle, Maide		To Code
C, Mal	thar traur		19a. Informant's Name/Relationship Anthony La Ruf 20a. Method of Disposition		20b. P	200	Barry	ville/			Barryv	ille, Ni Location - City o	12719
rmit. Pages 1 partment of H portant: If ital	njury or o		1 ABurial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe	cify)	ie	Place of Disponementery, cremotery, cremotery, cremotery	Nati	onal C	emete:	20/20 ry	006	Calverto	on, NY
permit. Departn	any ir		21. Signature of Funeral Service Li		od the deat	1	6000	Annapo	lis R	oad	Bowie,	ans Fune MD 207	eral Home 715
Physic /Med			shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aa	line.	00 CC	apr	i C	Ji as caldia	ic or respir	atory arrest,		Interval Between Onset and Death
le be executed Sician and		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence as a consequence	tic	Wal	ted le	ora Dise	av	2		hear
UNISION OF VIGAL MECOLUS, F.O. BOX 00/00, To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	2 Feta at time of d	Ideath 3	Ectopic pre					23d. Date of de Month	blivery Day Year
requires that	ep eq pino	by	Part II. Other significant condition	_	but not res	ulting in the u	nderlying ca	use given in l	Part I.	23		\d	o the cause of death?
cian: The law restricted has be	or, page 2 sh	e Completed	25. Was case referred to medical			J		26	Place of De	1	a. Was an autopsy performed? Yes 250	prior to death?	utopsy findings available completion of cause of s 2 No
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	y the funeral direct	Certification; To B	examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 6 Could no	t be 28e. Place of	njury Day Year) Injury - At ho	ER/Outpatien 28b. Time of Injury	f 28	Other: 4	☐ Nursing I	28d. De	Residence	and Number or F	acify) Jural Route Number,
spital or /	/ filled in b		29a. Certifier 1 Certifying	Physician: To the be	etc. (Specification of the state of my kno	wledge, death	h occurred a	it the time, da	ite and place	e, and due	y or Town, Sta	s) and manner a	s stated.
To tha Ho within 24 t To tha Fu	completely	Medical	(Check only one) 2 Medicel Expone) 29b. Signature and title of certifier	aminer: On the basis and manner	s of examina	tion and/or in	vestigation,	License num	, death occ	curred at th	e time, date a	nd place, and du late signed (Mon	e to the cause(s)
,-			30. Name and address of person w	no configreted cause of	f death (Item	23a) (Type,	Print) 5	20°	43 HOP V	82	AT	W:114	2000
	. Sta	te	31. Date filed (Month, Day, Year)	evoro Pagi	strar's Signa	-ve) B		202		י סרי	2122	1
Re	gistr	ar	APR 1 7 2	006	J. J.		E)						

			For State Registrar	State of Maryla			t of Heal			iene	16	4 35
	Physici	an	1. Decedent's Name (First, Middle, Last	_					2 Date of Deat Month		Year	3. Time of Death
	Physici /Medio		Yo Han	Lee					April	14,20		1638 M
j.	Examir	er	4a. Facility Name (If not institution, give					ation of Death		4c. County		
÷			Shady Grove Ad 5. Social Security Number 6. Se		s. last birthday)	If Under	ockvi.	LIE Inder 24 Hrs.	8. Date of Birth	Mon	tgom	
	Funeral Director			Дм 2□F 33		Months		ours Min.	(Month, Day, 5/21/	Year)		place (State or Foreign ntry) Sh.,D.C.
			Usual Residence of Decedent			l			3/21/	1712	was	511. , D. C.
	how		10a. State 10b. County MD Montgom		City, Town or Lo		rina					10d. Inside City Limits
	Ba-f	cto	MD Montgom	ery	Silve							1 ☐ Yes 2 🔀 No
	be filed within 72 hours after death with fhe Maryland Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Madical Exeminer must be notified at	al Director	500 Firestone	Drive		10f. Zip	2090!	5	1	0g. Citizen of U	What Cou SA	ntry?
	eme	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	lent of Hispan	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri	can Indian, etc.
2	hours after tural', or ite	by FL	1 Never Married 2 Married	1 ☐ Yes 2 🔀No If Yes, Give		1 ☐ Yes 2		ecify:		Specif	71 -	sian
3-003p	hours turaf	d be	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a Daca	dent's Heur	I Occupation			16b. Kind of B	usiness/ln	adustr.
ဂ်	filed within 72 Hygiene. Ither than "nal ent, the Wedic	Completed	(Specify only highest grad	le completed)	(Give	kind of wor	rk done during se retired)	most of work	ing	TOD. KING OF D	03111033/11	laustry
7	iene.	mo	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	Di	sabl	eđ			no	ne	
p	e filed othe vent,	Be C	17. Father's Name (First, Middle, Last)						(First, Middle, I	Maiden Sumar	ne)	
/land	uld be Mental Irked c	ToE	Jong M.Lee				(Chi Yo	n Choi			
Mar	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (T)	•		*			al Route Number			
	and lealth m 27		Jong M.Lee/Fath					-				,Md20905
<u>o</u>	nent of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Dament from Chate	. Place of Dispo cemetery, cre ate of	matory or o	ther place)	4/18/		20c. Location	•	own, State
baitimore,	The Partition of the Pa		4 □Donation 5 □ Other (Specify									
g n	permit. Pages 1 and 2 should b Department of Health and Menti Importent: If item 27 is marked eny injury or other traumatic ance.		21. Signature of Firm ral Service Liver						FUNER			E,P.A. q,Md20910
		-	23a. Part1. Enter the disease, or comp	lications that caused the de							OT TIL	Approximate
			shock, or heart failure. List only of fmmediate Cause (Final	ne cause on each line.	11	4	- 1		,			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a	equence of):	17	Teston				-	
	Examiner				5425.105 5.7.							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):							
	cuted nd ransi	Examine	that initiated events	c								
Š,	e exe ien a urial-1	EX	resulting in death) Last	Due to (or as a conse	equence of):							
2/p	ficate be executed physicien and is the burial-transit	dical		d								
_		/Me	fF FEMALE:	23c. ff yes, outcome of preg	mancy							
X Q Q	the death cert y the ettending iched for use a	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	Ectopic pr					ite of deliv	ery Day Year
j	of the de by the e tached t	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	, 352(1)	_ O(I) 61 (3p	oony)					
Į.		y P	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying c	ause given in	Part I.	23e. Did tol	oacco use con	tribute to t	he cause of death?
SD	requires that een signed b hould be deta	D D	Actic Vakel	1.2010					1 □ Ye	es 2 No	3 🗌 Prot	babły 4 ∏Unknown
cord	> 0 0	lete							24a. Was a	n 24b.	Were auto	opsy findings available ompletion of cause of
Ĕ	Physician: The law this certificate hes b al director, page 2 s	Completed by			-				autops perform	ned?	death?	2 No
VITA		Be C	25. Was case referred to medical				26.	Place of Death	(Check only on		1 🗔 1 03	200 140
<u>-</u>	Physician: r this certific ral director,	ToE	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpaties	nt 3 DC	A Other: 4	☐ Nursing Ho	me 5 Reside	ence 6 Oth	ner (Specia	fy)
n of			27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 2	8c. Injury at Work?		28d. Describe ho	w injury occur	red	
<u> </u>	Attendii death. ctor: A y the fu	catle	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗌 Yes					
DIVISION	of or Attend affer death Director: , d in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st <i>icify)</i>	reet, factory	r, office		28f. Location (St City or Town	reet and Numi n, State)	ber or Run	al Route Number,
_	pitel ours a erai (29a. Certifier 1 Certifying Phy	sician: To the best of my k	raculadae dost	h occurred	at the time d	ato and place	and due to the a			stated
	To the Hospitel or Attending within 24 hours affer death. To the Funeral Director: Affer the Funeral Director of the Pompletely filled in by the fune	Medical	(Check only one)	iner: On the basis of exami and manner stated.	ination and/or in	vestigation	, in my opinior	n, death occurr	ed at the time, d	ate and place,	and due t	o the cause(s)
	ro th within Fo the	Me	29b. Signature and title of certifier				. License nur		t t	9d. Date signe		
)(O/ Aa	6		1)2130	34	6	30/15	,20	06
	>		30. Name and address of person who o	ompfeted cause of death (ft	tem 23a) (Type,	Print)	0	/ 0	, ,,	,		1
			Daniel Golde	7 15225	SAGA	400	e old	100	tulle	MD a	208	30
Towns.	Sta Registi		31. Date filed (Month, Day, Year)	32. A gistrar's Sig	gnatury.	pode	,			J		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#14, perFH, 4/27/06, DPS, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death → Physician Lewis 4:00 AM Ruth 2006 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hopkins Hospita Baltimone The Johns City | If Under 1 Year | If Under 24 Hrs. | 8 | Date of Birth (Months | Days | Hours | Min. | 3 - 25 - 1920 5. Social Security Number 7. A e (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 21 F 86 Yrs. 230-22-6218 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or than "natural", or itema 23a or 28a-f ahow The Medical Examinar must be retified at 1 X Yes 2 ☐ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. 3330 N. Leisure World Apt 305 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Teacher School other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fannie Smellow Maurice Krasney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith L. Gillis/daughter 4 Stream Valley Garth Owings Mills, MD 21117 Health Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Important: If Ite any Interves of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 4-16-06 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 2 Danzansky, Coluberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licenses 1170 Rockville Pike Rockville, MD 20852 CA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** day /Medical Due to (or as a consequence of): Examiner Hydronephros 13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a conseq ence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-transit Bladder (anur resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe this certificate 1 Yes 1 Yes 2 No or Attending Physician: : After this certifical funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 TYes 2 TNo 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the tane, data and place, and due to the cause(s) and manner as stated. To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

19

DHMH 17 Rev 1/2001

, Medical Doctor

Johns Hopkins

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Res-000

Hospital, 600 N Walfe

State of Maryland / Department of Health and Mental Hygiene

					artment of I rtificate of			Reg. No.	14137
		1. Decedent's Name (First, Middle	e, Last)				2. Dete of De		3. Time of Death
	Physician	Janie	Long				April	Day Year 12, 2006	11:00AM
	/Medical Examiner	4a Fecility Neme (If not institution				4b. City, Town, or I			
	LXaiimiei	Lowledge Change No.	dwa Ilawa			Bowie M	arvland	Prince G	enroec
	Funeral	Larkin Chase No. 5. Social Security Number	6. Sex 7. Age	(In yrs. lest birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. Bir	thplace (State or Foreign
	Director	578-48-2346	1□ M 2ÅF 91	Yrs.	Months Deys	Hours Min.	Jan. 1.	3, 1915 Sou	thplace (State or Foreign buntry) th Carolina
	- V	Usuel Residence of Decedent							
ylan	Mo W	10a. State 10b. County		10c. City, Town or Lo Bowie	ocation				10d. Inside City Limits
W	tor its	Md. Prince	Georges	DOWLE					1 🖾 Yes 2 🗆 No
£	or 28	10e. Street end Number			10f. Zip Code 2072) 1		10g. Citizen of What Co United Sta	ountry?
E.	r items 23a or 28a-f s ricer must be notified Funeral Director	15205 Dunleigh	Drive		2072	2.1		onitted bed	CCS
daa		11. Maritel Status	12. Was Decedent Ev Armed Forces?	ver in U,S. 13.	Was Decedent of I	Hispenic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race - Ame Black, Whit	
affer C	파를 교	1 Never Married 2 Marri)	1 ☐ Yes 2 ☑ No				lack
27275-0020 d within 72 hours af	of P	3 ☑ Widowed 4 ☐ Divorced	Yeer or Dates:		71			оросту.	
2 2 2	et de la	15. Decedent (Specify only highes	's Education it grede completed)	16e. Dece (Give	dent's Usual Occu kind of work done	pation during most of wor ed)	rking	16b. Kind of Business	/Industry
Z į	ng u	Elementary/Secondary (0-12)	College (1-4or 5+)	House	<i>DO NOT u</i> se retire ewife	ed)		none	
N p	tal Hygiena. d other than "naturel", c event, the Medical Exat Be Completed by					40 Mathada Nas	nn (First Middle	Maidan Curnama)	
₽	d out	17. Father's Name (First, Middle, aunavailable	Last)			Emma	Carter	Maiden Surname)	
	Men Men To								
72	is m	19a. Informant's Name/Relations	nip (Type, Print)					er, City or Town, State, Md. 20720	Zip Code)
and	m 27	James Long/Son		20b. Place of Disponentery, cres					Town Chats
Saltimore, Maryland Jemit. Pages 1 and 2 should be file	Department of Health and Mental Hygiena. Important: if fem 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State		Date	20c. Location - City or			
E g	ury or	4 Donation 5 Dother (Sp	pecify)	Ft. Lince				Brentwood,	
	Depart Import any inj once.	21. Signature of Funeral Service I	icensee					Funeral Hom	
п я	Q = 9 9	Walph 1	1 Alles	31	531 Georg	gia Avenu	e, N.W.	Washington	, DC20011
255		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the	ne death. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Ph	ysician	0110011, 01 110011 12110101 2101	,						Onset and Death
	Medical	Immediate Cause (Final disease or condition	Respira	tory Fail	ire				
E	caminer	resulting in death)	V	ue to (or as a consec					
70	je je		Pneumon	ia					1
cute	nd trens	Sequentially list conditions,	D	ue to (or as a consec	quence of):				1
. §	urial urial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Genera	ıl Debilit	У				1
58/5U, icate be executed	been signed by the attending physician and should be detached for use as the burial-trensit ieted by Physician/Medical Examiner	that initiated events resulting in death) Last	Du	ue to (or as a conseq	uence of):				
	Me as		d						
death certif	r use		0						
a dea	d by the attending letached for use a Physician/M	Part II. Other significant conditio	ns contributing to deeth but	not resulting in the u	nderlying cause gi	iven in Part I.	23b. Did	tobacco use contribute	e to the cause of death?
Ords, P.O	Phy t	Urinary Track I	nfection				10	Yes 2. TXNo 3. □ P	robably 4 🗆 Unknown
es ∫	be of	orinary frack i	IIIection						
COLOS,	sen s ould	Congestive Hear	t Failure				24a. Was perfo	an autopsy 24b. med?	Were autopsy findings available prior to
a ec	2 sh							- 1	completion of cause of death?
L o	this cartificate has been s ral director, page 2 should TO Be Completed						10	Yes 2⊡xNo	1 ☐ Yes 2 反 No
	artifica ctor,	25. Was cese referred to medical examiner?				26. Place of Dea	ath (Check only o	nne)	
OT VITA	direct direct	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpetier	nt 3□ DOA Ot	her: 4X Nursing H	lome 5□ Resid	dence 6 □Other (Spe	ecify)
10 F	h. After th funeral tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey	Year) 28b. Time o	28c. Inju	ry et ork?	28d. Describe	how injury occurred	
	or daath. ctor: After by the funer tification	2 Accident investig	ation		M 1	Yes 2□No			
UIVISION or Attanding	after daath. I Director: After d in by the funer	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or R vn, Stete)	ural Route Number,
5 🔓	rs after daath. al Director: After the in by the funers Certification:			,					
deo	within 24 hours after To the Funeral Dir completely filled in Medical Cerl	(Check only 2 Medical I	g Physician: To the best of examiner: On the basis of e	my knowledge, deetl	occurred at the to	ime, date and place	e, and due to the	cause(s) and manner e date and place, and du	s steted. e to the cause(s)
# #	the F	one)	and manner state						
	with To to	29b. Signature and title of certifier	in mi		29c. Licen	se number		29d. Date signed (Mon	ın, ∪ay , τθθτ)
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٩	6		J'		D43Z1	. /		April 12,	2006
٩	6	30. Name end eddress of person v	who completed cause of dee	eth (Item 23e) (Type,	Print)		-1. 35		2006
) L	6	30. Name end eddress of person v Adebonale, Ajay (31. Dete filed (Month, Day, Year)	/MD 6201 Gree	eth (Item 23e) (Type, enbelt Roa 's Signeture	Print) ad #M5 Co		rk, Mary		2006

amend #10b-f Per Inf G886 12/04/08 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April **Physician** Cohen Lublin Rose 13, 2006 6:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Casey House Montgomery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 21X F 83 Min 484-12-8711 Yrs. Director 12-30-1922 Usual Residence of Decedent 10c. City, Town or Location Potomac permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show eny Injury or other treumatic event, the Medical Examination to motified at an once. 10a State 10b County 10d. Inside City Limits Montgomery Anne Arundel 1 Yes 2 □ No Director Annapolis MD 10718 Potomac Tennis Lane 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20854 21401 123 Spa View Ave U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store Entrepreneur 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ida Epstein Frank Moscow ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7447 Quincy Hall Court Springfield, VA 22153 Lee Cohen-, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon 4-17-06 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Dame zanoky of Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licensee 1170 Rockville Pike Rockville, MD 20852 A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Exami that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificete 1∐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospice ဥ this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. nerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) D35635 April 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) State **APR 19** 2006 Registrar

		· ·	State of Maryla	nd / Depa	artmer		ilth and N	lental Hy		06	14139
* 5 +	- 3	1. Decedent's Name (First, Middle, Last)					-	2. Date of De Month	ath Day	Year	3. Time of Death
Physic /Medi		Flora June Long						April			4:30 P M
Exami		4a. Facility Name (If not institution, give st	reet and number)		4b. City	, Town, or Loc	ation of Death		4c. C	ounty of Deat	th
		41250 New Market T	urner Road		N		csvill.	e	St	t. Mar	y's
Funeral Director		220-01-4993	M 200 E	s. last birthday) 86 Yrs.	If Unde Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da June 1,	th y, Year) 1919	9. Bird Co Ma	thplace (State or Foreign ountry) ryland
death with the Maryland ims 23a or 28a-f show rmust be notified at	or	Usual Residence of Decedent 10a. State 10b. County Marry 1 and Ct. Marry 1		City, Town or Lo		110					10d. Inside City Limits 1 ☐ Yes 2 No
the N 28a-1	Director	Maryland St. Mary	5 1	леспапт		ip Code			10g. Citize	n of What Co	ountry?
With With	0	41250 New Market T	urner Road			2065	9			USA	
death ms 2	Funeral		2. Was Decedent Ever in	U.S. 13.	Was Dece	edent of Hispan	nic Origin? (Sr	pecify Yes or No Rican, etc.)	- 14	. Race - Ame	
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 the 12 fem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		1 Tes, sp	**	pecify:	Hican, etc.)		Black, Whit pecify:	e, etc. White
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and 2 sh lealth and m 27 Is m		19a. Informant's Name/Relationship (Type Martin Paul Long /		A.	•	•		rai Route Number			Zip Code) .11e MD 20659
Demit. Pages 1 a Department of Hes Important: If Item any injury or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Q	.Place of Dispo cemetery, cre ueen of P emetery	osition (Na matory or Peace	ame of other place)		Date 8. 2006		ation - City or	
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ician: Th certificate rector, pag		25. Was case referred to medical				re-west-wit-	. Di(D	1 Yes	2 XN0	1 🗆 Yes	2 X No
	o Be	examiner?	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	- 2 CT C	1 04		th Check only o		70th ea /C-	
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- 22	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, facto	ory, office		28f. Location (City or To		Number or R	ural Route Number,
To the Hospital of within 24 hours af To the Funeral D completely filled is	Medical C	29a. Certifier 12 Certifying Phys (Check only one)	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, deal	th occurre nvestigation	d at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner a: lace, and due	s stated. e to the cause(s)
To th within To th	Me	29b. Signature and title of certifier				9c. License nu			29d. Date	signed (Mont	th, Day, Year)
		1,10	an le			1)000	050	6		4/2	4/06
		30. Name and address of person who con	mpleted cause of death (II	em 23a) (Type	, Print)	-				· · ·	
		Leon Berube, M.D.	28170 Old	Village	Rd 1	lechani	csvill	e MD 206	559		
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2 5 20	32. Registrar's Sig		hand						

06-02852 Please Type or Print in Black Indelible Ink Robert A. Lagana State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day April 27, 2006 Year 1136 hrs **Medical Examiner** Robert Alan Lagana 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's Southern Maryland Hospital Clinton . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Davs Hours Min Director 215-98-2651 41 ct. 17, 1964 Countr Wash., DC 1 X M 2 Yrs Usual Residence of Decedent 10d Inside City Limits 'n 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 X No St. Mary's s 23a or 28a-f shove e notified at once. MD Mechanicsville death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g Citizen of What Country' 20659 42204 Ridge Road U. S. A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2XX Married Yes 2 X No "natural", or _{Specify}White f Yes, Give Year Widowed Divorced 1 Yes 2 X No specify: ğ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry permit Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "naturinjury or other traumatic event, the Medical Examinjury or other traumatic event, the Medical Examinium Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 rofessional Painter Painting 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Salvatore Lagana Sr. Jane Marie Shackleford Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy J. Lagana / Wife 2204 Ridge Road Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 2,2006 Ll<u>eonardtown, MD</u> **Q**harles Mem. Grdns. Donation 5 Other Specify 22. Name and Address of Facility ature of Funeral Service Licenses Brinsfield-Echols Funl. Hme., P.A. 30195 Three Notch Rd. Charlotte Hall, MD 20622 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cocaine and narcotic intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED AMENDED item#23a,27,28a-f,perME,G855,5/10/06 TT attending physician for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. Box 68760, IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? 1 🗸 Yes Yes 2 No 26 Place of Death (Check only one) 25 Was case referred to medical Division of Vital Be Other₄ Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 2 28a Date of Injury (Month, Day, Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natural 1 Yes 2 No 5 Pending Funeral Director: rely filled in by the Fnd 4/27/2006 Fnd 10:33 Am unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building. etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5845 Allentown Way Could not be Suicide (Specify) found on street Homicide Camp Springs. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 28, 2006 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAY 0

🐲 Registrar's Signature

State Registra

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 29, 2006 **Physician** 1445 James H. Morrison /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∏** M 2□ F 76 Yrs. Director West Virginia 197-22-1059 May 11, 1929 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified a Director 1 ☐ Yes 2 ☑ No Aberdeen Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 848 Gilbert Road 21001 U.S.A. or Iteme 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Date\$: 951 – 53 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced Atrash/Sim natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 0 Civil Service U.S. Government 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel McCormick Harrison Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Patricia Morrison (Spouse) 848 Gilbert Rd. Aberdeen, Maryland Depertment of Heali Importent: If item 2 eny Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 3/06 Bel Air, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses inskn Hrug Ungles De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit una Mas a co. P.O. Box 68760. Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No hes certificate the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No death. investigation Director: , 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours aft Funerel Di Tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated within 2 29b. Signature nd title of c 29c. License number 29d. Date signed (Month, Dey, Year) 04/29/06 who completed cause of death (Item 23a) (Type, Print) Havre De Grace Wr MI) State Registrar

			For State Registrar	State	of Maryl		partment of F			giene	6	14/42
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	/Medic		4a. Facility Name (If not institution,		umber)	IVIIIICI	4h City Town o	r Location of Deat			y of Death	11.03
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	Funeral Director		178-14-3996	1 M 2 □ F		Yrs.	Months Days	Hours Min.	(Month, Da	3, 1921	Cou	place (State or Foreign
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	land		10a. State 10b. County		100	. City, Town or I	ocation				Ţ.	10d. Inside City Limits
	Many	ō	WV Mine	ral		Ridg	jeley					1 ☐ Yes 2 ☐ No
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Health and M		Michael McCart	• •			et and Number or Ri lbank Rd.			(te, Zip Code) ID 21532
0		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		matory or other p	^{ласе)} Мау	Date 1, 2006	20c. Location - Cit	y or Town, State
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		Menungena	m, M.D.		R	56207		April 2	21502
la la		30. Name and addr of person who	completed cause of death	(Item 23a) (Type	Print)		1		

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	ret.		For AMEND#26 Per PHY	State of Maryland	/ Depa	rtment o	f Health and	•	-	-
			Registrar AACO HEALTH DE		Cer	tificate (of Death		Reg. No.	17177
п	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Dea	Day 2006	3. Time of Death
	/Medio		Hildegard Marg	aret Gertrude I	Macint			Prac	3 - 0-2	03.201 M
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36	I', or	by F	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2【X	No Specify:		Specify:	White
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<u> a</u>	should bants a marked umatic e	10	Alfred Lange				Anna Fi	riedrich		
Maryland	C1 C0 C0 C0		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailing	Address (Str	reet and Number or F	Rural Route Numbe	r, City or Town, State, .	Zip Code)
	s 1 and 3 f Health Item 27 othar tra		Ken MacIntyre (So:	N. 19	606 S	herry	Drive, Eld			
0	Pages 1 nent of H int: If Ite iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	e of Dispos letery, crem	ition (Name of atory or other	place)	Date	20c. Location - City or	Town, State
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	Do not ente	r the mode of	dying, such as cardia	ic or respiratory ari	est,	Approximate Interval Between Onset and Death
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	<u>a</u> = <u>a</u>	L:u	27. Manner of Death		Bb. Time of	28c. li	njury al	1	ow injury occurred	sily)
10	Attending I ir death. ector: After by the funer	atio	1	(WOTH)	Injury	(Work? I □ Yes 2 □ No			
Division	after death after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, offi	се	28f. Location (S. City or Town	treet and Number or Run. State)	iral Route Number,
	vital or urs afte ral Dir lled in									
	Hospital Hospital Funaral tely filled	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sicien: To the best of my knowle ner: On the basis of examination	dge, death o and/or inve	occurred at the	e time, date and plac ny opinion, death occ	e, and due to the c urred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Hospital or Atte within 24 hours after de To the Funaral Directo completely filled in by the	Med	29b. Signature and title of certifier	and manner stated.			ense number		9d. Date signed (Monti	
	⊢ 3 ⊢ ŏ		15 Cheles	1	N)	G	4514		1 1 1	
			30 Name and address of person who co	intoleted cause of death (Item 23	Ba) (Type, P	rint	70.	0	the mis	
		(SWARATO	asol Hoen	Ital	Bur	1e Gle	u Bu	me mis	3HO61
100	Sta		31. Date filed (Month, Day Year)	32 Registrar's Signature	9	5	U			
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene () 6 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 17 2006 **Physician** Year EDNA MARIE HAWKINS MIDDLETON 7:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Year 1 □ M 2 □ F Months Days Hours Yrs. Director 212-26-9809 84 OCIOBER 17, 1921 MARYLAND Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director MARYLAND CHARLES NEWBURG 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 10565 MT. VICTORIA ROAD / P.O. BOX 15 20664 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ 3X Widowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) ollege (1-4or 5+) 5 YEARS TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental FRANK HAWKINS, SR. MAMIE ADELL PATTERSON HAWKINS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 19m 27 DEBORAH THOMAS / NIECE 3307 NORTH ROLLING ROAD, WINDSOR MILL, MARYLAND 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEM. APRIL 24,2006 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Smature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Multisystem /Medical Examiner Athuorderous + Thrombs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760 Completed by Physician/Medical ihe use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 212 No 1 ☐ Yes 2 ☐ No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Inpatient 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA completely filled in by the funeral dir 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of gery 29d. Date signed (Mpnth, Day, Year) 29c. License number D-46419 who completed cause of death (Item 23a) (Type, Print) CHARLENE Α. LETCHFORD MD 404 E. CHARLES ST. LAPLATA XX 20646 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registrar

			1 - For State Registrar	State of Mar	yland / Dep	artm	ent of H		Mental Hyo		06	And the second of the second o
			Decedent's Name (First, Middle, Last))					2. Date of Dea	ath		3. Time of Death
	hysicia		Evelyn Louise	e Meise					April	16	Year 2006	7:30P
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. C	ily, Town, a	r Location of Dea	<u> </u>		nty of Death	7.301
			Carroll Hospi	tal Cent	er	Wes	stmin	ster		Car	roll	
Fu	ineral		5. Social Security Number 6. Se	x 7. Age ((In yrs. last birthday) If Un	der 1 Year	If Under 24 Hrs	8. Date of Birth	1		place (State or Foreig
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£ :	s or 28a-f show be notified at	<u>lr</u>	10e. Street and Number			10f.	Zip Code			10g. Citizen o	of What Cour	ntry?
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7) 70 gg	5 E	Ŧ	1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 ‡ No If Yes, Give			s 2∰ No	Specify:	10 / 110411, 010.)		eity: Whi	
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			Registrar 1. Decedent's Name (First, Middle, Last,		Cei	unicate of	Deall	2. Date of Death	j. No.	O Time of Booth
	Physici /Media			LER				Month	Day Year	3. Time of Death
3	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of Dea	
			Chapel Hill Nurs			Randa	llstown		Balti	
	Funeral Director		212321200	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jan. 22	(ear) 9. Bir (Co 1909 M	thplace (State or Foreign ountry) aryland
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	eation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or flams 23a or 28e-f show event, the Medical Examinar must be notified at	ō	MD Baltin			allstown				1 □Yes 2XXNo
	28e-	Director	10e. Street and Number			10f. Zip Code		100	2. Citizen of What Co	ountry?
	3a or		4511 Robosson Ro	ad			1133		Jnited Sta	
	death rms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.)		Hispanic Origin? (Spe an, Mexican, Puerto I		14. Race - Ame	encan Indian,
ဖွ	after or Ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give		f Yes, sp <i>e</i> cify Cub 1 ☐ Yes 2 🛛 No		Hican, etc.)	Black, Whit	e, etc.
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Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		20a. Method of Disposition		cemetery cren	sition (Name of natory or other place	cal	ate 20	c. Location - City or	Town, State
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ati	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	90	P11	. Name and Addre	ss of Facility	. 1 . II		
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Box	n cert anding use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna		let			23d. Date of deli	very
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Division of	deat deat ctor: y the	lica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome farm stre			Rf. Location (Stree	at and Number or Ru	ral Route Number
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	splte		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, death	occurred at the tin	ne, date and place, a	nd due to the caus	e(s) and manner as	stated.
	To the Hospitel or Attanding Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examir one)	er: On the basis of examina and manner stated.	ition and/or inv	estigation, in my o	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To tha Hospitel within 24 hours a To tha Funarel I completely filled	Σ	29b. Signature and title of certifier	5.54		29c. License			Date signed (Month	
	· grad		162 K	S.RAO.TIC)	DL	13462	AP	210 12 3	1006
	WV.		30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type, F	Print) 12.5.	NAO. M.	2	0 :	
	6		2400 OLD COM	and the second search (Item 32 Registrar's Signar	08 1	LAWDA	LLJTOU	171 20	0 2113	3
	Sta		31. Date filed (Month, Day, Year)	32/Registrar's Signa	ture da	rolle)				
	Registr	ar	APR 1 9 200	A CHARLES A	19700					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month 0500 AL 2000 Facility Name (If not institution, give street end number) City, Town, or Location Death 4c. County of Death OI+al e (In yrs. last birthday) 93 Yrs. 5. Social Security Number DU Birthplace (State or Foreign Country) 6. Sex Months Days 1 X M 2□ F 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Milling 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GeHy 5 College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Neme of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pat 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SO 11 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yae 24d110 1 ☐ Yes 2 ☐ No 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Dinpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28d. Describe how injury occurred Injury at Work? 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificete be executed attending physician and I for use as the burial-transit Division of Vital Records, P.O. Box 68760 tor: After this certificate has been signed by the in the funeral director, page 2 should be deteched Diractor: After this certificate has To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Diractor: After this certifica

Physician/Medical Examiner

Completed by

Be

2

Certification:

Medical

Physician

/Medical

Examiner

Physician

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Funeral Director

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Be Completed

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic evant, the Medical Examiner must be notified at

25. Was case referred to medical examiner? 1 Yes 2 No

3 ☐ Suicide

29a. Certifier

4 Homicide

5 ☐ Pending investigation 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the pause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertitier

29c. License number

29d. Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print) Son MD < 31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

completely filled in by

APR 12 2006



			For 1 = State Registrar	Jugo 1	State of		nd / Dep	artme	nt of H			•		006	14149
	Physicia		1. Decedent's Name (First, M	iddle, Last)			-					2. Date of De Month	ath Day	/ Year	3. Time of Death
	/Medic		Neal McCa									APRIL	7	2006	
i.	Examin	er		SPITA	L			EL	KTON					CECIL	
L	Funeral Director		5. Social Security Number 2) 3 58 108 Usual Residence of Deceden		M 2□F 7.	Age (In yrs.	last birthday)	Month:	er 1 Year S Days	If Under Hours	Min.	8. Date of Bir (Month, Da March 27			nplace (State or Foreign untry) imore, MD
	land ow		10a. State 10b. Cou			10c. C	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary Interior	į	DE No	ew Ca	stle	T	ownse	nd							1 ☐ Yes 2 No
	th the	lrec	10e. Street and Number					10f. Z	ip Code				10g. Citi	zen of What Co	untry?
	ath wi	Funeral Director	634 Grears	Cor	ner Ro	oad				9734				USA	
	er de	nue	11. Marital Status		2. Was Decede Armed Force	es?	J.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	ispanic Ori In, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	-	 Race - Ame Black, White 	
50	irs aft	by F	1 ☐ Never Married 2 ☐ I		1 □ Yes 2 If Yes, Give Year or Date	EXNO es:		1 ☐ Yes	2 ∑ No	Specify:				Specify: W	hite
2-002e	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the Hygiene then "neturel; or Items 23a or 28a-1 show ent, I're Madical Exemitant mast be mailled at		15. Dece	dent's Edu	eation		16a. Dece	dent's Us	ual Occupa	ation	A = 4 = = = 4 × 2		16b. Ki	nd of Business/	Industry
7	ithin 7 19.	Completed	(Specify only his Elementary/Secondary (0-1		College (1-4	or 5+)	life.	DO NOT	use retired	during mos ()	t of worki	ng			
7	led wi ygien her th	Con	12				Che	mica	1 Op	erat					turing
yland	l be fil ntal H ed otl ever	Be	17. Father's Name (First, Mid Neal Will:		n							(First, Middle,		Sumame)	
چ	hould id Mei mark metic	ျှ	19a. Informant's Name/Relat				19b Maili	ing Addre	ss (Street a			e Coop		r Town, State, Z	in Code)
Ø ≥	ulth an 27 is riveu		Patricia N			fe								nsend,	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Execute 1: or teams 23a or 28e-1 show any injury or other treumetic event, the Marical Executive rivative routified at once.		20a. Method of Disposition			20b.	Place of Dispo cemetery, cre					ate		cation - City or	
ballimore	Page ment c ent: If ury or		1 ¶Burial 2 ☐ Cremati `4 ☐ Donation 5 ☐ Othe		omoval from Sta	ate	nside Ce			- 1	April	12, 2006	5 Wax	odstown i	New Jersey
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			shock, or heart failure. Immediate Cause (Final	List only or	e cause on eac	Line					cardiac d	ir respiratory ai	rrest,		Approximate Interval Between Onset and Death
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00	icate physics sthe														
X	n certil nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outco			7					2	23d. Date of deli	very
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1□Live birtl 4□Pregnan 9□Unknow	t at time of		Dther (pregnancy specify)				- 1	Month	Day Year
г Э	at the	Physician/Med	9 □Unknøwn												
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ב	The ate h page	Com											rmed2 2 No	death?	2 □ No
<u>a</u>	Physicien: rthis certificaral director,	Be	25. Was case referred to med examiner?	-	ospital:				0#			(Check only o			
5	Physical direction	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death		· · · · · · · · · · · · · · · · · · ·		ER/Outpatie		OOA Cure	er: 4 □ Nu		me 5 Residence 128d. Describe 1		Other (Spec	sify)
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2	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of	Injury - At h	ome, farm, st	reet, facto	ory, office		- 1				ral Route Number,
5	tel or s afte el Dir	Cert	4 Hornicide		building	, etc. (Speci	·y)				1	City or Tov	vii, State,	,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical	29a. Certifier 1. Cert. (Check only one) 2 Medi	fying Phys cal Exemin	icien: To the be er: On the basi and manne	is of examin	owledge, deat ation and/or in	th occurre	d at the tim on, in my op	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of cer	tifier /	1			2	9c. License		26			e signed (Month	
			· Fall	ftt	/	MI)		D 00	0634	86		APF	マルノナ,	2006
)	C.		30. Name and address of per			,									
)		10	31. Date filed (Month, Day Y	ear) _	106 E	rar's Sign	treet	, E1	kton	, MD	2	1921			
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	/Medic Examir		4a. Facility Name (If not institution, give s Coastal Hospica 5. Social Security Number 6. Sex	treet and number) At the	Lake s. last birthday)	4b. City, Sal	1560	Location o	Md	8. Date of Birth	U	ounty of Death	CO lace (State or Fore	nian.
	Funeral Director			M 2/2 F 4	34.	Months	Days	Hours	Min.	(Month, Day, 10–30–1	Year)	Coun	EGE PARK	•
	he Maryland 286-f show otified at	ector	10a. State 10b. County MD WICOM		SALISBI	URY							0d. Inside City Lim	
	with t	ID.	10e. Street and Number 2410 ST. LUKES RAC	מע		10f. Zip	Code	21	804	1	0g. Citize	en <i>o</i> f What Coun USA	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "nature!, or iteme 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Deced f Yes, spec		spanic Orig n, Mexican,		city Yes or No- Rican, etc.)		I. Race - Americ Black, White,		
21215-0036	d within 72 ho jiene. r then "natur the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usua kind of wo DO NOT us TEAC	rk done d se retired)	uring most	of workin	ng .		of Business/Inc	,	
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Mar	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (Typ			-					,	Town, State, Zip	,	
	ges 1 an t of Heal if item 2 or other		JOHN MOORE - SPOUS 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b	Place of Dispo cemetery, cren	sition (Nan	ne of			-		LAND 218 ation - City or To		
Baltimore,	permit. Par Department Importent: any Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses			l. Name an	d Address	s of Facility	BOU	NDS FUNI	ERAL	SBURY, M	NC.	
	40 = e a		23a. Part1. Enter the disease, or complic	ations that caused the de								, MARYLAN	Approximate	
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Metastat Due to (or as a consi	equence of):	Bre	a T	4 (En C	en			Interval Between Onset and Death	
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<u> </u>	sician certifi iractor	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	ospital:	TER/Outpation	4 AC DO	Othe			(Check only on				
ion of	To the Hospital or Attending Physician: The law within 24 bounts after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2	ertification: To	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work	4 🗆 Nur	2	8d. Describe ha		Other (Specify occurred)	
Divis	ital or Atters after de al Directo	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of the C	home, farm, stre	eet, factory	r, office		2	8f. Location (St. City or Town		Number or Rural	Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one) 2 Medical Examin	ician: To the best of my k er: On the basis of examinand manner stated.	nowledge, death	estigation,	, in my opi	inion, death	f place, and occurre	d at the time, da	ite and p	lace, and due to	the cause(s)	
)	J. William J.	-	29b Signature and title of certifier	1 WW	O	290	License		278	> 2	od. Date	signed (Month, L	O G	
	Par		30. Name and address of person who con Devid E. Conall, N	no Coestal	Hospire	Print)	Bux	/73	3	Salis	1-	, MD	2180	<u>_</u>
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature .	melle	,				0			

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Physic /Medi		Ozetta Christ								94	24	_0	Ö	0535 A
Examii	ner	4a. Facility Name (If not institution SOCRED HE	AIST HOS		ال	Ci	Sme		AN	D		County of		14
Funeral Director		5. Social Security Number 233-34-5566	6. Sex 7	'. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D July I	7, Year)	22	COUR	ney, WV
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Lim
Marylan -f ehow led at	ţō	WV Hampsh	nire	Ror	mey									1 X Yes 2 ☐ 1
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s 1 and 2 f Health Item 27 I		Diana Foreman 20a. Method of Disposition		20b. F	LAZ3 P					e, Cent				
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permit. Page Department of Important: If any Injury or once.	П	4 □ Donation 5 □ Other (S			anch Mo	Dunta 2. Name ar		-	-		Inr	ee U	nurc	hes, WV
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	$ \mathbf{r} = 0$	27. Manner of Death	28a. Date of	Injury	28b. Time of		28c. Injury Work	4 🗀 140		ne 5 Resi				<u></u>
fun Affe	텵	1 Accident 5 Pending	9	Day Year)	Injury	М		:? ∕es 2 🔲:	No					
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To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)	g Physician: To the b Examiner: On the bas	is of examina	wiedge, death tion and/or in	occurred vestigation	at the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and mann place, and	er as st	ated. the cause(s)
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	stayed.			c. License							Day, Year)
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			Derr (10)				():	200	0		HT2	(C	44	2000
10		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type,	Print)	A	1	1	1 11		1	1	
-		Sr. Kohert W 31. Date filed (Month, Day, Year)	Elik 70	4 Seta	on Ar	NE	Cu.	mbe	rlai	icl, M	ary	land	1 .	21502
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		For State Registrar	State of Maryl		artment of I			giene Reg. No. 06	14152
Physicia	n	Decedent's Name (First, Middle, Last, LLC)		Manult	v		2. Date of De Month April		3. Time of Death
/Medic		4a. Facility Name (If not institution, give		FRIODI	4b. City, Town,	or Location of De		4c. County of	
	de D	Lorien Tane			Taney			Carro	
Funeral Director		5. Social Security Number 6. Se 220–16–2211		rs. last birthday 1 Yrs.	If Under 1 Year Months Days		Ain. (Month, Da	iy, Year)	Birthplace (State or Foreign Country)
ס		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or L	anation .		Jan. 12	2, 1925 I	Maryland
Maryla -f shor	į	Maryland Carrol		Taney					10d. Inside City Limits 1 1 Y Yes 2 □ No
or 28s	Director	10e. Street and Number 459 Third S	treet		10f. Zip Code 2178	27		10g. Citizen of Wha	at Country?
Jeath v na 23e	Funerai	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.			? (Specify Yes or No	USA - 14. Race -	American Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural; or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Exam or must be confilled at once.	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates: 194		If Yes, specify Cub 1 ☐ Yes 2 🛣 No		? (Specify Yes or No uerto Rican, etc.)	Specify: T	White, etc. Thite
5-0	eted	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Occu	during most of	working	16b. Kind of Busin	ness/Industry
Maryland 21215-0036 nd 2 should be filed within 72 hours att lith and Mental Hygiene. 27 Is marked other than "natural", or reaumatic event, the Medical Exert	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		n Fabrica	,		Outdoor	Advertising
be filed ntal Hyging of other	Be C	17. Father's Name (First, Middle, Last)	20-1-27-31			18. Mother's I	Name (First, Middle	, Maiden Sumame)	
laryland 212- 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tham	2		ncis McNult					Rosenstee	
and 2 st and 2 st lealth and m 27 ls n		Joan McNulty/spou					r Rural Route Numbe Town, MD	er, City or Town, Sta 21787	ite, Zip Code)
Baltimore, permit. Pages 1 at Department of Hea mportant: If item any Injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - Cit	
Baltimo	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens					or.29,2006 Skiles Fu	_	•
Dermi Depa Impo any Ir		John M. &	Telles MOO				St., Tan		
Physician		23a. Parv. Enter the disease, or complete book, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the cone cause on each line.	eath. Do not en	1 1 .	hatilus		rrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					30/07/2
A uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
68760, < cate be executed physician and ithe burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of):					
687 tiflicate I	edica		d						
Records, P.O. Box 68760, < The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etaf death 3	Dectopic pregnance Other (specify)	у		23d. Date o Month	f delivery Day Year
S, P.	by Ph	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	underlying cause gr	ven in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
w require	eted						10	Yes 2 2 10 3[□ Probably 4 □Unknown
Il Records, The law requires tate has been signe page 2 should be	Completed							osy prio ormed? dear	re autopsy findings available r to completion of cause of th? Yes 2 \(\text{No} \)
Vita sician: certific rector.	e P	25. Was case referred to medical examiner?	lospital:		Ott	or · /	Death Check only o		
Division of Vital or Attanding Physician: 1 after death. Director: After this certifical in by the funeral director.	tion: to	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatie 28b. Time of Injury	of 28c. Inju	ry at	g Home 5 Residence 1	dence 6 Other (Specify)
Division all or Attend a after death in Director: / id in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp		reet, factory, office		28f. Location (S City or Tox		or Rural Route Number,
ne Hospi in 24 hou he Funer pietely fill	edicai	29a. Certifier (Check only one) Certifying Physical Exemi	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, deal	th occurred at the traversing attom, in my o	me, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
To the within To the complex c	Ž	29b. Signature and interior certifier	Calo	(N) (N)	29c. Licens	3166	5	29d. Date signed (A	2006
6+1		30. Name and address of person who co		Item 23a) (Type,		er Ave	JUR 60	2 NINGS	The macylast
Stat Registra		31. Date filed (Month, Day, Year)				•			277

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** McKenzie 2006 11,1 dred /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth 10301Christie Rd. Magor 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Davs Hours 1□ M 2□ F ΜĎ Director 302-38-9073 100 Feb 6, 1906 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1□ Yas 2□ No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Somerville Ave Apt 707 21502 USA Funerai Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. nt: If item 27 Is marked other then "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Specify: white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 X□ Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 cook nursing home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Samuel Cunningham Flora Evans Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 119 Mullen Street MD 21502 Mary Growden daughter Cumberland 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depentment of 1 x Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 4/27/2006 MD mportant Cumberland 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate nterval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) Medical 6 mm Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed nding physician end use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown signed I þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed has 2 No 1 ☐ Yes 2 ☐ No 1 Tes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4—Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 No death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital 29a. Certifier 💶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 27,2006 D0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 Neti

Registrar's Signature

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Registrar

ATPollino
31. Date filed (Month, Day, Year)

MAY 0 3 2006

06-02798 Please Type or Print in Black Indelible Ink Leslee Jo Moon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** 0900 hrs LESLEE JO MOON April 25, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death 2800 block Savage River Road Swanton Garrett If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or **Funeral** oreign Director Months Days Hours Min 213-80-8073 10-6-1963 Country) MD M 2 xF 42 Usual Residence of Decedent 10b. County Ę 10a. State I0c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show must be notified at once. Yes 2 x No MD Garrett Swanton should be filed within 72 hours after death with the Maryland Director 10e. Street and Numbe 10f Zin Code 10g. Citizen of What Country? 1779 Savage River Road 21561 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Armed Forces Never Married 2 X Married White etc. Yes 2X No Widowed Divorced If Yes, Give Year Yes 2X No specify Specify white other than "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ event, the Medical Baltimore, MD 21215-0036 beautician salon it Pages 1 and 2 should be filed within riment of Health and Mental Hygiene 17. Father's Name (First_Middle_Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nancy Jo Phillips Richard Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Moon-husband 1779 Savage River Rd., Swanton, MD 21561 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State mportant: 4/29/2006 Hillcrest Mem. Park Cumberland, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses Scarpelli Funeral Home, PA Virginia Avenue, Cumberland, MD 21502 Hart I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ailure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 ✓ Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury FOUND: Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver of car involved in collision FOUND: Natural Pending 1 ✓ Yes 2 No Funeral Director: the Apr 25, 2006 0840 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Local Street 2800 block Savage River Road, Swanton, MD Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

OCME 2006

State

PI

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

200

32. Registrar's Signature

1161

Ana Rubio MD.

31. Date filed (Month, Day, Year

MAY U

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 26, 2006

		1	For Stata Registrar	State of M	aryland		rtment of H tificate of L		R	eg. No.) 6	14155
	Physicia		Decedent's Name (First, Middle						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	James Emo			r.	4h City Town or	Location of Death	April 13,	7	y of Death	10:23 P M
	Examin	er	227 Welch Way	, give street and number)			Lothian				Arunde	1
	Funeral		5. Social Security Number		ge (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
	Director		578-56-5026	XXXM 2□F	61	Yrs.	Working Days		July 20,	1944	Washi	ngton, DC
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryl	Ď	Maryland Anne Ar	Indel	Т	othian						1 ☐ Yes 🗶 No
	r 28a	Director	10e. Street and Number	URGET		ou mai	10f. Zip Code			l0g. Citizen of	What Cour	ntry?
	th with	ai D	227 Welch Way				20711				USA	
	ems	Funerai	11. Marital Status	12. Was Decedent Armed Forces	7	. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Ra Bla	ice - Americack, White,	can Indian, etc.
36	ours after death with the Marylan rel', or Items 23a or 28a-1 show Exertice Incitition	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Pivorced	ied 1 ☐ Yes 2 ∑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🙀 No	Specify:		Speci	ity: W	hite
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pu	d tal	Be	17. Father's Name (First, Middle,					18. Mother's Nam			ime)	
Maryland	should be nd Mental i marked c umatic sve	2	James Emory More			19h Mailir	ng Address (Street		y Erlene P		n, State, Zij	Code)
Ma	क क ज		Mary Frances Bauer I	-	life		Wilson Road		112/210/14 (146)			
ā,	s 1 and 2 of Health item 27 other tra		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of matory or other place		Date	20c. Location		own, State
Ë	Page ent c nt: If ry or		1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (S)	as Crem			9, 2006	Edgewat	er, Ma	ryland
Baltimore,	permit. Pag Department Important: eny injury o		21. Signature of Feneral Service	dicenseer las		22	2. Name and Addre	ss of Facility Geo ill Road Ox	rge P. Kal on Hill, N	as Funer Aryland	ral Hon 2072	ne PA 15
			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that cause	ed the death.	Do not ent	er the mode of dyir	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Pnysician i		Immediate Cause (Final disease or condition	<u> </u>		hosi	s o	7 6	Liver			Onset and Death
	/Medical		resulting in death)	Due to (or a	s a conseque	ence of):	ΔΛο	f .d. 00	2			8
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	ted	nine	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z zwere to a	a a actinoque	Street City						
<u>,</u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseque	ence of):						
68760,	icate be executed physician and s the burial-transit	edicai		d							_	
Ψ,	ng ph		IF FEMALE:				-			T	-200	19
Вох	law requires that the death certifica as been signed by the attending pl 2 should be detached for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3	Ectopic pregnancy	1			ate of deliv Month	ery Day Year
0.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time or dea	atn 5L	Other (specify) _					
Δ.	res that the disigned by the be detached		Part II. Other significant condition	ons contributing to death	but not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
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Re	The lav ate has page 2	E O							perfo	med?	death? 1 Yes	
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nc On	ding F	tion	1XXXNatural 5 ☐ Pendir	ng (Month, D		Injury	Wo	rk? Yes 2 □ No	200. 2000	,,		
Division	Attending r death. sctor: Atter	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of I	njury - At hor	me, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Nun	nber or Rur	al Route Number,
Ö	el or satter	Certification:	4 Homicide	building,	etc. (Specify))			Chy or row	m, State)		1
	To the Hospitel or Attenk within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai (29a. Certifier XX Certifyii (Check only one)	ng Physician: To the bes Examiner: On the basis and manner:	of examinati	vledge, deal ion and/or in	th occurred at the till evestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
	To the	₩ E	29b. Signature and title of certifie	er a	2		29c. Licens			29d. Date sign		
			MAINE	Allender	Phy	योटा-	- D	19427		4-	14-	
			30. Name and address of person				T) .	T 1	M 7 .	00/75		
	153		Anwar Alit. Munsh 31. Date filed (Month, Day, Year,		pital R		303 Prince	Frederick,	Maryland	20678_		
	St Regist	ate rar	APR 1	7 2006	was d	B 6	and I					

Bruce James Montgomery

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Projection For 1 benomery Amendment (Model Auri) Frequency Dame & Mont gomery Frequency Dame				1- For State Registrar			Cei	rtificat	e of	Deatl	ነ			R	eg. No.	60	UO	14100
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	tne hospital or Attent hin 24 hours after death the Funeral Director: npletely filled in by the	Medical	(Check only 2 Medical Examone)	miner: On the bas and manne		tion and/or in	vestigation,	, in my op	oinion, dea	ith occurre	od at the time,	date and p	lace, and du	e to the cause(s)
4	vithin 2 To the comple	ž	29b. Signature and title of certifier		_)			number	_) -			•	th, Day, Year)
1			101	21	1	,		HO	059	573	21	4.	-26-	06
7	100		30. Name and address of person who	completed cause	of death (Item	23a) (Type,						,		•
' /	·O'		Jennifer Schmid					Road	l, Ca	lifor	nia, M	ary1a	nd 206	519
· ·	Sta	ite	31. Date filed (Month, Day, Year)	32 Pmc	istrar's Signa	ture								
광	Registr		APR 2 6	2006	ر میروی	K A	as all	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 3 per doc 101 21, per fh 9855 5-4-06 yt

State of Maryland 7 Department of Health and Mental Hygiene

1- State Registrar Amend item #6-9,14820b Per Filips 165950 (1867) JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 05, 2006 Year Physician 7:00 p M Nanephosy Keomany /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George 7. Age (In yrs. last birthday)

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 3/4
| 76 | 71 Yrs. | Months | Days | Hours | Min. | Nov 11, 1929 5. Social Security Number Birthplace (State or Foreign Country) **Funeral → X X X** F 257-35-8633 Director Thailand Loas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or iteme 23a or 28a-f ahow the Madical Exercise count be notified at O Stafford 9 Thaxton Court, Stafford, VA 1 Yes 2 No 22556 Director Va 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Thaxton Court 22556 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White Asian þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker At Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, SINRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Noy Bouthasane Noun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Emily Chanthavong 9 Thaxton Court, Stafford, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/09 /2006 1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) Potomac Crematory 4/16/2006 Dale City, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dale Robert McCollon per dvr Mountcastle Funeral Home, 4143 Dale Blvd, City, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPUXIC encephalopathy **Physician** days /Medical Due to (or as a consequence of): Hypertensive heart disease Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical as JE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? on dialysis, End stage renal disease 1 Yes 2 No 3 Probably 4 Unknown Trackeostomy Diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No myucardial Infarction, Hypethension 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury death. 1 Yes 2 No investigation within 24 hours after death.

To the Funeral Director: completely filled in by the fi 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061614 RSINDHWAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 CLINTON, MARYLAND 9131 PISCATAWAY RUAD 31. Date filed (Month, Day, Year) 32 registrar's Signature State Registrar MAY 0 4 2006

		1 - For State Registrar	State of Ma	aryland				ealth a Death	and M		Reg. N	6 U I]6	14159
Physic	an	Decedent's Name (First, Middle, Last)	14							2. Date of Month	D	ay	Year	3. Time of Death
/Medi		Eva Nicke							4 D 15	april		7	2006 of Death	1:10 P. M
Examir	ner	4a. Facility Name (If not institution, give s		II		1		Location o		,		Howa 1		
	6.0	Morningside Health			ist birthday)		r 1 Year			8. Date of	Birth			lace (State or Foreign
Funeral			/. Ад ім 2 X і́ F	100	Yrs.	Months		Hours	Min.	03/05	Day, Yea	r) 6	Cour	Virginia
Director	1	Usual Residence of Decedent		100						03703	/ 100		West	721821124
/land		10a. State 10b. County		10c. City,	, Town or Lo	cation							1	0d. Inside City Limits
Man Man	tor	Maryland Howard		E11i	cott	City								1 XYes 2 No
th the	Director	10e. Street and Number				10f. Zi	p Code				10g. 0	Citizen of	What Cour	itry?
th will	alD	5330 Dorsey Hall D	rive				042_				USA	Ţ <u>-</u>		
dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	6. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Orig in, Mexican	gin? (Spe ı, Puerto I	cify Yes or Rican, etc.)	No-		ce - Amend ick, White,	
or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2X 1 If Yes, Give	No		1 🗆 Yes	2 X □ No	Specify:				Specia	fy: TTland	L _
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nat nat	lete	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	kind of w	ork done i use retired	during most	t of workii	ng			ment	
withir and then then	F G	Elementary/Secondary (0-12)	College (1-4or 5	5+)		etar		•				-	lture	51
filled Hygin ther	O O	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Mid				
d be file antal Hy Ked oth	To B	John Stephen Buck						Nancy	E11	en Tu	ttle			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28e-f show amy injury or other traumatic event, the Mudical Exerciting must be notified at ones.	1	19a. Informant's Name/Relationship (Ty			19b. Mailii	ng Addres	s (Street	and Numbe	er or Rura	l Route Nu	mber, City	y or Town	, State, Zip	Code)
ulth all		Lois Morrill/ Dau	ghter		5185	Dow	nwest	Ride	e Col	umbia	, MD	210	44	
S 1 a	1.0	20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Na	ame of other plac	(e)	D	ate	20c.	Location	- City or To	own, State
rmit. Pages operant: If it portant: If it by Injury or		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Me	emetery, crei Ston emory	ewál Gard	l ens		04/22	2/2006	Man	assa	s, VA	
mit.		21. Signature of Funeral Service Licens	99					ss of Facilit	Robe	rt E.	Eva	ns F	unera	1 Home
Dermi Depermi		1/1/1	<u> </u>		1	6000	Anna	apolis	s koa	d Bow	ie,	Mυ 2	0715	
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certifical	led	IF FEMALE:			1.									-
5, F.C. DOX 001 00, es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[⊒Ectopic ⊒ Other (pregnancy specify) _	/			-		ate of deliv Ionth	ery Day Year
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e la has	Completed									р	utopsy erformed		death?	mpletion of cause of
_ F 5 6	e Co	25. Was case referred to medical			10,700			26 Place	e of Death	n (Check or	s 2.Der	NO	1 🗆 162	213140
⊒	0 8	avaminer?	Hospital:	ient 2 🗆	ER/Outpatie	nt 3 🗆 [OCA Ott			me 5 🗆 F		6 🗆 🔿	ther (Speci	fy)
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Attending For reading For reading For sector: After by the funer	at lo	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ay rear,	Injury	М		Yes 2	No					
DIVISION of Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At ho tc. (Specify	ome, farm, si	treet, facto	ory, office				on (Street Town, St		ber or Rur	al Route Number,
To the Hospitel or Ati within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	rsician: To the best iner: On the basis of and manner s	of examinat	wledge, dea tion and/or i	th occurre	ed at the ti on, in my o	me, date a opinion, dea	nd place, ath occuri	and due to red at the ti	the cause me, date	e(s) and n and place	nanner as e, and due	stated. to the cause(s)
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		> K/C	MA				053	636			A	wil	17,2	006
		30. Name and address of person who of	completed cause of		n 23a) (Type	, Print)	che	tes	Ri	Colu	mhi	er l	up à	2694
NO what C	tate	31. Date filed (Month, Day, Year)	7. Regist	trar's Signa	iture				<u> </u>				7	
Regis		APR 1 9 200	06	- B	A And	out)								

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State of Maryland / Department of Health and Mental Hy

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		1- For State Registrar	Co	ertificate of D			2006 eg. No.	14160
Physic Medical Exam				NT	τ.	Date of Dea Month	ith Day Year	3 Time of Death
(⁴		4a. Facility Name (if not institution, give	A. street and number)	Nair 14b. 0	otty, Town, or Location of D	April 2, 20	4c County of De	1849 hrs
46 m	v bag	St. Agnes Hospital			altimore		40 County of Br	sau)
Funera Director	Ì	5. Social Security Number 6. Se 212-88-4528		- I	Under 1 Year If Under 24 Ionths Days Hours	Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9.	Birthplace (State or reign
2,100,01		Usual Residence of Decedent	M 2 F 34	Yrs.	Ionina Days Hours	Jan.	11,1972	Country) MD
/ япу		10a State 10b. County		ly, Town or Location				10d. Inside City Limits
daryland 28a-f show 1 at once,	وَ	MD Alle	gany (Cumberland				1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number		10	f. Zip Code	1	0g. Citizen of What C	ountry?
72 hours after death with the Maryland "matural", or items 23a or 28a-f sho at Examiner must be notified at once.	ral		VENUE 12. Was Decedent Ever in	ILS 13 Was De	21502 cedent of Hispanic Origin?	(Specify Vos es No	USA	
· death or iten	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No		pecify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc	nerican Indian, Black,
rs after rral",		3 Widowed 4 Divorced	If Yes, Give Year		2 No specify:		Specify:	White
5-0036 led within 72 hours aft Hygiene, other than "natural" the Medical Examine	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's Us during most o	sual Occupation (Give kind f working life. DO NOT use	of work done retired)	16b. Kind of Busines	ss/Industry
	dm	12		Labo	orer		J.L.D.Con	struction
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2121 ould be fi d Mental s marked	0	19a. Informant's Name/Relationship (Ty		19b. Mailing Add	ress (Street and Number	Edith Wil		ate Zip Code)
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Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is nijury or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition crematory or other pl	ace)	Date	20c. Location - City	or Town, State
Baltimord permit. Pages I Department of I Important: If Injury or other		4 Denation 5 Other Specify: 21. Sona ure of Funeral Service License	Sc		ineral Home	4/6/2006		
Ba perm Dep Imp Inju		110m Ff	M		pelli Funeral	Home.PA	Cumberla	inia Ave nd, MD 21502
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y, P.O. Box 68' ires that the death certification is signed by the attending be detached for use as it.	Physician	1 Yes 2 No 9 Unknown	9 Unknown	5 Other (S	Specify)	N. Williams		
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g 5 7	Completed					24a. Was ai autops perform	y prior to	utopsy findings available completion of cause of
Il Rec In: The I rufficate I or, page	ပိ	25. Was case referred to medical			26.Place of Death (Chec	1 Y Yes 2		es 2 N o
Vital hysician: this certif	8	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	Other -		esidence 6 Other	er:
- # ~ #	no.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month Day, Year) Apr 2, 2006	28b. Time of Injury 1630 hrs	28c. Injury at Work?	28d. Describe ho Unknown	w injury occurred	
Division tal or Attendi rs after death. al Director: A	icati	2 Accident Investigation	28e. Place of Injury - At h		1 Yes 2 No			
Divis	Certification:	3 Suicide 6 ✓ Could not be determined	(Specify) Parking Lo		ory, office building, etc.	or Town, Sta		ural Route Number, City Baltimore MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: 0	To the best of my knowled	ge, death occurred at	the time, date and place, ar	nd due to the cause	(s) and manner as sta	rted
To the within To the complet	Medical	2 Medical Examiner: O al 29b. Signakure and title of certifier	n the basis of examination and manner stated.		my opinion, death occurred			
		(arol 1	Jallan		O.C.M.E.		April 3	
1	-	30. Name and address of person who con	·	23a)			14, 1, 31	2000
1					t, Baltimore, MD 212	01		
St: Regist		31. Date filed (Month, Day, Year)	32. Regidirar's Signatu	of the same	W			

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/Medi Exami				ive street and numb reater Was		ton		, Town, or kvill	Location of	f Death			County of Dea	ath
uneral irector		5. Social Security 1 279-94-4		Sex 7. 1 X M 2 □ F	Age (In yrs	s. last birthday) Yrs.	If Unde Months	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi 127257	rth a Y.91 a7	9. Bi	rthplace (State or Foreig Country) Ukraine
-		Usual Residence of 10a. State	of Decedent 10b. County		10c. C	City, Town or Lo	ocation							10d. Inside City Limit
Hede	tor	MD	Montgo	omery		Rockv								1 XYes 2 N
other traumatic event, the Mudical Examinar must be notified at	Funeral Director	10e. Street and Nu 6121 Mon		ad			10f. Zi	ip Code 20	852			10g. Citiz	en of What C	ountry? ced States
	by Funer	11. Marital Status 1 Never Mari	ried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X No		Was Dece If Yes, spe		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	ecify Yes or No Rican, etc.)		4. Race - Am Black, Whi	
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li:	Be	17. Father's Name	Neshikova	cky		Sc	ienti	ıst			(First, Middle	, Maiden S	Iydrolo Gumame)	ogic
מבתחופה ב	2	19a. Informant's N Boris Ne Boris Ne				19b. Mailir 1705	Address	s (Street a			I Route Numb nna VA		Town, State,	Zip Code)
h		20a. Method of Dis	position Cremation 31	Removal from Sta	20b.	Place of Dispo cemetery, cres	sition (Na	me of	9)	D	ate	20c. Loc	ation - City or	Town, State
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			- FUI	Department of Health and Mental Certificate of Death	Hygiene 006 14162
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	Funeral Director		5. Social Security Number 194–12–6011 Usual Residence of Decedent 5. Social Security Number 1 □ M 2 ☑ F 7. Age (In yrs. last bir	Severna Park rthday) If Under 1 Year If Under 24 Hrs. 8. Date (Mor Yrs. Months Days Hours Min. Apr.	of Birth of
	the Maryland 28a-f show	ector	10a. State 10b. County 10c. City, Town MD Anne Arundel 10e. Street and Number	n or Location Severna Park	10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?
36	in 72 hours after death with the Maryland "natural", or itsma 23a or 28a-f show solical Examinantial be notilised at	by Funeral Director	506 Red Oak Drive 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	21146 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	USA or No- 14. Race - American Indian,
121215-0036	d within 72 giene. ir than "na the Medis	Completed		Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Agent 18. Mother's Name (First,	16b. Kind of Business/Industry O'Connor, Piper & Flynn
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	es 1 and 2 of Heelth a fitem 27 is r other tra		Anne Stewart/Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	673 Quail Run Court, Arno of Disposition (Name of try, crematory or other place) Apr. 21,	20c. Location - City or Town, State
Baltimore,	permit. Pag Depertment important: i sny injury o once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Pohns Cemetery 2006 Barranco & Sons, P.A. S 495 Gov. Ritchie Hwy, S	everna Park Funeral Home everna Park, MD 21146
	ate be executed hysician and hysician and hysician and the buriat-transit	i Examiner	23a. Part. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)	cholangiocavcil	Interval Between
P.O. Box 68760,	death certific e ettending p ad for use as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting it.	5 Other (specify)	23d. Date of delivery Month Day Year 3. Did tobacco use contribute to the cause of death?
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Division	ital or Attending rs efter death. al Director: After led in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office 28f. Loc	ation (Street and Number or Rural Route Number, or Town, State)
)	To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated. 29b. Signature and title of certifier W. W	nd/or investigation, in my opinion, death occurred at the 29c. License number 0005 9173	e time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 4 - 17.06
	Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) KATHLEEN A LEMMEN M.D. 31. Date filed (Month, Day, Year) APR 1 9 2006	900 Bestaute Rof#300	Annapolis, MD 21401

			1 - For State Registrar	State of	f Marylan	-	artment o			nd M	lental Hy	/giene	06	Printered and Park	63
	, ž	or The second	1. Decedent's Name (First, Mid	ldle, Last)			_				2. Date of D	eath		3. Time	of Death
	Physici /Medi		John Carlin (O'Grady							Month April	20	2006	8:30	M a C
	Examir		4a. Facility Name (If not instituti	ion, give street and nun	nber)		4b. City, To	wn, or Lo	ocation of	Death		4c. Co	unty of Death		
			St. Mary's N	ursing Cent	er		Leon	ard	town			St	. Mary'	S	
	Funeral		5. Social Security Number		7. Age (In yrs. i	iast birthday)	If Under 1 Y		If Under 2		8. Date of Bi	irth			or Foreign
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	r dez	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	S. 13.	Was Decedent f Yes, specify	t of Hisp Cuban.	anic Origi Mexican.	in? (Spe Puerto	cify Yes or N	0- 14.	Race - America Black, White, e		
36	or It	by Fi	1 Never Married 2 Ma	If Yos Giv	2 🗍 No 8		1 ☐ Yes 2 🗓		Specify:		, , , , , ,				
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Baltimore,	permit. Pages Department of H Importent: If Its eny injury or of		1 ☑ Burial 2 ☐ Cremation	3 Removal from S	State 200. Pi	emetery, cren	sition (Name on natory or other	r place)	ĺ	U	ate	20c. Locati	on - City or To	vn, State	
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				() LUVP		6	Δ	61	088	38		641	25/	66	•
	3	1	30. Name and address of Sor	n who comple d cause	of death (Item	23a) (Type F	Print)					/	/		
			Dr. Rakhi				town, I	Mary	land	206	550	,	950		
	Sta Registr	te	31. Date filed (Month Day Year APR 2		gistrar's Signati		وكالمعا								

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

nans-Jurgen Fiitzkat April 24, 2006	3 Time of Death
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County	^{rear} 1058 hrs
10 Olchard Dilve	ty of Death
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/ 77)	YY) 9. Birthplace (State or
Director 212-67-9822 1X M 2 F 54 Yrs. Months Days Hours Min. July 30, 1951	Foreign
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
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Maryland Cecil Port Deposit Top Maryland Cecil Port Deposit	any ce - American Indian, Black,
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Specify. 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify. Specify. Specify.	White Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of B Commodified 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Vind of B Commodified 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Vind of B Commodified 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Vind of B Commodified 18c. Vind of B Commodified 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Resident Signature (First, Middle, Last)	mercial/ idential
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토수월류등 4 Donation 5 Other Specify R. A. Perris & Co. Inc. 2000 Penns	sylvania
103 W. Stockton Street. Elkton	Maryland 21021
Physician Wedical 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line	eart Approximate Interval Between Onset and
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3 Suicide 6 Could not be determined (Specify) Single Family 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Numb or Town, State) 16 Orchard Drive, Port Dri	
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check only 1 Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and on and manner stated. 296 Synatuke and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	er as started. due to the cause(s)
and the same of th	ned (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a)	- 1
2 Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Pay Year) 4 2006 32. Redistrar's Signature Registrar	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Richard Edward I		1- For State	State of Ma		partment of ertificate of		nd Mental	-	Reg No 200	16 14 165
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, RICHARD E		ITTS, J	R .			2. Date of De Month April 18,	eath Day Year	3. Time of Death 1501 hrs
\bigcirc		4a. Facility Name (if not in:	stitution, give street a			4b. City, Town, Easton	or Location of De		4c. County of Talbot	Death
Funeral Director		5. Social Security Number 213-76-87	39 ₁ x _{M 2}		s. last birthday) 43 _{Yrs}					9. Birthplace (State or Foreign Country) W.VA
land f show any once,	or	Usual Residence of Deced		10c. C	ity, Town or Locat	East			-	10d Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number 10054 Lon	gwoods R	oad		10f. Zip Code	1601		10g Citizen of What United	States
death w	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4	Married Arm 1 1 v Divorced If Yes, Giv or Dates:		1f Y	es, specify Cub	oan, Mexican, Pui No <i>sp</i> ec <i>ify:</i>		10- 14 Race - White, Specify:	American Indian, Black, etc. White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygieu. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Completed t	15. Decedent's Education Elementary/Secondary (11 t.h		st grade completed) ege (1-4 or 5+)	during m		pation (Give kind ife. DO NOT use Paver		16b. Kind of Busin	nstruction
21215-0036 und be filed within 7 Mental Hygiene marked other than c event, the Midica	8	17. Father's Name (First, Marchard E) 19a. Informant's Name/Rel	. Pritts		19b. M ailin	g Address (Str	Virg	inia M	, Maiden Surname) Oorehead umber, City or Town,	State, Zip Code)
ore, MD. s 1 and 2 sho of Health and If item 27 is		Sheila Pri 20a. Method of Disposition 1 X Burial 2 Cre	1	20	6843	Hunti	ing Cre	ek Rd.	Hurlock 20c. Location - C	, MD 21643 ity or Town, State
Baltimore, permit. Pages I ar Department of Hee important: If ite			her Specify:	Hi A Mala	ill Cre	st Cem Name and Addre amptom	etery ess of Facility Funer	4/24/06 al Home Marylan	Federal	Lsburg, MD
Physician /Medical Examiner		23a Part I Enter the disea failure. List only one Immediate Cause (Final di	cause on each line	that caused the dea	ath. Do not enter t	he mode of dyir	ng, such as cardia	Marylan ac or respiratory a	I (I rrest, shock, or heart	Approximate Interval Between Onset and Death
	er	or condition resulting in de Sequentially list conditions if any, leading to immediat	s, b. Due to (o	r as a consequence						
	Examiner	cause. Enter Underlying (Disease or injury that initi events resulting in death)	iated C.	r as a consequence	e of)·					
e be buri	Medical	X UNPENDED		DED item#23a item#4a yes, outcome of pr		erME,g856	, 6/12/06 5	IT	23d Date of de	bliven
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	Physician/M	23b. Was decedent pregna past 12 months? 1 Yes 2 No 9	ant in the 1 1 1	Live birth Pregnant at time of Unknown	2 Fe	etal death :	3 Ectopic pre	gnancy	23d. Date of de Month	Day Year
S, P.O. uires that the in signed by the detache	2	Part II. Other significant of Chronic alo		ting to death but no	ot resulting in the i	underlying caus	e given in Part I	1Y	6S 2 No 3	ite to the cause of death? Probably 4 Unknown
of Vital Records, ig Physician: The law requirement of the configurate has been some and inector, page 2. should heral director, page 2. should	Completed							neri 1 ✓ Yes	opsy prio formed? dea	re autopsy findings available or to completion of cause of ath? Yes 2 No
~ ≟ . < ₽ !	cation: To Be	25. Was case referred to n examiner? 1 ✓ Yes 2 N 27. Manner of Death 1 ✓ Natural 5	Hospital: 1	Inpatient 2 Date of Injury (Month, Day, Year)	ER/Outpatient	DOA Injury 28c. Ir	Other Nunjury at Work?	rsing Home 5	Residence 6 🗸	
Division To the Hospital or Attendia within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certificat	2 Accident 3 Suicide 6 4 Homicide	Could not be	Place of Injury - A	t home, farm, stre	et, factory, office	e building, etc.	28f. Location or Town,		or Rural Route Number, City
To the Hos within 24 h To the Fun	Medical ((Directing of the	ying Physician: To th al Examiner:On the b and man							
F × F 8	Me	29b. Signature and title of		RI			nse number		29d. Date signed April 19, 200	(Month, Day, Year)
3		30. Name and address of p Zabiullah Ali, M.E		d cause of death (It edical Examin		n Street, Ba	altimore, MD	21201		
Sta Regist	ate rar	31. Date filed (Month, Day	0 1 2006	32 Registrar's Sign	nature /os	de				

		1. Decedent's Name (First, Middle, La	·			te of Death	2. Date of Death		3. Time of Death
Physic /Med		Shir1	ey Marie Will:	s Pierce	е		April 1	6, 2006 Year	4:00 P. M
Exami		4a. Facility Name (If not institution, gi		ter	4b. City,	Town, or Location of Dea		4c. County of Death Prince G)
Funeral		5. Social Security Number 6.	Sex 7. Age (In y	rrs. last birthday,		r 1 Year If Under 24 Hi			place (State or Foreig intry)
Director		237-62-9014 Usuat Residence of Decedent	1□M 2 X F 65	5 Yrs.	Months	Days Hours Mii	October	7,1940 No.	rth Caroli
how	_	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
tal Hygiene. Id other then "natural", or itame 23e or 28e-f ehow event, the Modical Exeminar must be notified at	Director	Maryland Prince	e Georges	Upper					1X Yes 2 □ No
3a or	Ö	167 Joyceton Ter	rrace		10f. Zip	20774		g. Citizen of What Cou Jnited Sta 1	•
me 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Dece	dent of Hispanic Origin? (crify Cuban, Mexican, Pue		14. Race - Ameri	ican Indian,
or Its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1	1 Yes, spec		rto Hican, etc.)	Black, White Specify: B1 a	
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r than	mo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)			are Provider		Domestic	2
al Hygi I othar vent, I	Be C	17. Father's Name (First, Middle, Last	")	,			ame (First, Middle, Ma	aiden Surname)	
	To E	Joseph Wills				Marth	a Richar	cdson	
		19a. Informant's Name/Relationship	,, , ,	1		s (Street and Number or F			
Health		Nigel Paree Pier				leigh Drive;			
2= 5		20a. Method of Disposition 1 X Burial 2 Cremation 3	THOMOTEL HOME DIEGO	cemetery, crei			il 22,2006	c. Location - City or T	own, State
ntmen ortant: njury njury		4 □ Donation 5 □ Other (Special Signature of Funeral Safvice Lice				ony Memoria		andover, M	laryland
Departr Imports any inju			2 4-15		Name an	Horton Comp	any Mortic	ians, Inc.	
S. 1		23a. Part1. Enter the disease, or com	pplications that caused the de	eath. Do not ent	ter the mod	ennedy Stree	t,N.W.;Was	shington,D.	
ysician		shock, or heart failure. List only	one cause on each line			ie oi dying, such as cardia	ic or respiratory arres	I.	Approximate
IVSICIAII		Immediate Cause (Final							Approximate Interval Between Onset and Death
		Immediate Cause (Final disease or condition resulting in death)	a metasta	a siste		wo Cor Cinio in			Interval Between
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	siciar	1	1. Decedent's Name (First, Middle, L Alfred Pea	ast)			-			2. Date of Dea Month 4-16-2	ath	Vone	3. Time of Death 6:42PM M
	edica mine	r	4a. Facility Name (If not institution, g Holy Cross Ho	ive street and number)	rs. last birthday)	Sil	ver	Location of D	ng		4c. Mc	County of Deat	ery
Direct	tor		577-70-1372 Usual Residence of Decedent	1 2 F 49	_ 55 Yrs.	Months	Days		Min.	B. Date of Birtl (Month, Day 1 - 27 - 1	/, Year) 95 7	1951 50ut	hplace (State or Foreign budtry) Ch Carolir
the Marylan 28a-f show	Cicario		Md Prince 10e. Street and Number		City, Town or Lo	Hil					40. 011		10d. Inside City Limits 1X Yes 2 □ No
with	į	5	4127 Atmore P	lace		10f. Zip						izen of What Co	untry?
In yiallo Z 12.15-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I im marked other then "natural", or Items 23a or 28s-1 show aumatic event, the Madical Examinar must be notified at	NA FILL	2	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?				spanic Origin i, Mexican, F Specify:	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		JSA 14. Race - Ame Black, White Specify:Bla	e, etc.
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be filed tal Hygi d other	200	ם ב	17. Father's Name (First, Middle, Las	,	1 11	uck .		18. Mother's		First, Middle,	Maiden		
should ind Men marke	Ę		Johnnie Pears 19a. Informant's Name/Relationship		19b. Mailir	na Address	(Street ar			Yarbo		i gh r Town, State, 2	Tip Codo)
1 and]]	Louise Pearson	, Mother		Atm	or P			Hill	s M	d 2074	8
permit. Pages 1 a Department of Hee Important: If Item			1 Donation 5 Dother Spa	□ Memoval from State	cemetery, crer t Oliv	natory or o et	ther place	4	/22/	2006	Was	cation - City or Shingte	on DC
Deparmit Departing Imported	Suce		21. Signature of Funeral Septice Lic	Type V?	1	722	Nort	of Facility h Ca	Tay pita	ylors al Str	Fur eet	neral H	Tome
Physicia /Medic			23a. Part1. Enter the disease, or conshock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	polications that caused the de- y one cause on each line. Cardiop Due to (or as a conse	ulmona				rdiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
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cuted	Examin		cause. Enter Underlying Cause (Disease or injury that initiated events	Uremia									
icate be executed physicien and sthe burial-transit	dical Ex		resulting in death) Last	Due to (or as a conse		ialy	sis						
ath certifi ettending tor use as	Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging the pregi	tal death 3	Ectopic pro					2	3d. Date of deliving Month	very Day Year
w requires that the de been signed by the c should be detached	۵		Part II. Other significant conditions	contributing to death but not re	esulting in the un	nderlying ca	ause given	in Part I.					the cause of death?
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with To t	Σ	2	29b. Signature and title of certifier	L 11 a							signed (Month,	, Day, Year)	
(4)		3	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, f		000	6410	0	0	4)	16/06	
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×	arylar abov	_	MD Carro	-11		ty, Town or Lo							10d. Inside City Limits
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	ē = =	F	1 □ Never Married 2 H Marri	Armed Force	s?	.3.	If Yes, specif	fy Cuban	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		Black, White	
A 936	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Date	**		1 ☐ Yes 2	₩ No	Specify:		5	Specify: Asi	an Indian
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Ba	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If item 27 is marked any injury or other traumatic avonce.) 81- (I)	-0 .	100723	1			'Eli Tain St.	ne Fune	eral H	Home 0 2107	· A
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<u>_</u>	ding Ph h. After th tuneral		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of fr (Month, I	njury Da <i>y</i> Year)	28b. Time of Injury		c. Injury a Work?		28d. Describe l	now infury	occurred	
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Division of Vital Records, P.O. Box	or At ifter of Direct in by	Certification:	4 Homicide determine	ned 28e. Place of building,	Injury - At he etc. (Specif	ome, farm, str 'y)	eet, factory,	office		28f. Location (3 City or To		Number or Run	al Route Number,
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	To the Hospital or Attend within 24 hours after death To the Euneral Directors completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of my knowledge death accurred (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.						nion, death occur	ed at the time,	date and p	lace, and due t	o the cause(s)
	To the vithin 2 To the complet	Me	≥ 29b. Signature, and title of certifier 29c. License numb									signed (Month,	
	WIL		Annaly Con 039						05 4	17	4	tlirlo	6.
	My	30. Name and address of person who come ted cause of death (Item 23a) (Type, Print) Syen S. Hosain Ma 447, East Main St Westwimter						1	1 1				
_				osain mo			st Ma	in	St Ne	stwin	ster	MA	21157
	Sta Registr		31. Date filed (Month, Day, Year) $\Delta PR = 1$		strar's Signa		Speak.	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marie Raymonde Paul April 19 10:20 A^M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5969 Grand Banks Road Columbia Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 F 219 96 3118 69 Dec 26, Director 1936 Haiti Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Tyes 2 No MD Howard Columbia Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5969 Grand Banks Road 21044 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2XNo 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Yes. Give Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietary Assistant Nursing Home if Health and Mental Hygid Itam 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Tancrede Mathurin Emilie Mauger 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean V. Paul/Son 3053 Memory Lane Silver Springs, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If its
any injury or of
once. 1 € Burial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cem. 4-22-2006 Ellicott City, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service M01044 ollino 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 months **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑No Records, P.O. the detached 9 Unknown 9 Unknown ģ peugis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 8 1 🗌 Yes 5 DM 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has page 2 certificate 1 ☐ Yes 25No Division of Vital 2 € No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 - Homicide n 24 hou. the Funeral Dire 29a. Certifier Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D55778 April 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Price 11055 Little Patuxent Parkway Columbia, MD 21044 32/Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2000 APRUL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month Dey Physician Eleanor Petracca 26, April 2006 /Medical 7:00 P.M. 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Vincent Care Center Emmitsburg Frederick If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. last birthdey) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Davs Hours 1 □ M 212 F Months Director 207-14-1905 82 Sept. 14, 1923 Pennsylvania Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Marylend nant of Health end Mentel Hygiene. 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 G Yes 2 □ No Director Frederick Emmitsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 South Seton Avenue Funeral 21727 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ☐ Yes 2 ☑ No Yes, Give 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Religious Community Elementary/Secondary (0-12) College (1-4or 5+) College 5+ Teacher Notre Dame De Namur 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Petracca Rose Arcaro 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Camilla Harant 333 S. Seton Avenue, Emmitsburg, MD 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from Stete **Department** 4 □ Donation 5 □ Other (Specify) SISTER OF NOTRE DAME 5/1/06 ILCHESTER, MD. 22. Name and Address of Fecility SKILES FUNERAL HOME 21. Signature of Funeral Service Licensee 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner attending physician and for use es the bunai-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) ned by the at datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown been signed à page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? this cartificate has 2 X No 1 YES 1 ☐ Yes 2 ☐ No i or Attending Physician: after death. eral Director: After this cartifica filled in by the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 ☐ Yes 2 🖾 No Other: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00440 man 37 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) n PORT NO ICREW PEL IER DaNITH J. 31. Dete filed (Month, Day, Year) MAY 0 3 2006 . Registrar's Signature State

Registrar

			For State Registrar		State of	Marylar			of Hea		lental Hy	giene () Reg. No.	06	14/7/
			Decedent's Name	(First, Middle, La	st)						2. Date of De	ath		3. Time of Death
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	with the Maryland a or 28a-f show the collified at	tor	MD	Anne Aı	runde1		Odentor	n						1 ☐ Yes 2☐ No
	or 28	Oire	10e. Street and Num	ber				10f. Zip (Code			10g. Citizen	of What Cour	
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980	ours after de rai', or item Examiner	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4	_	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? XXNo	'	Was Decede f Yes, speci 1 ☐ Yes 2		iic Origin? (Spe exican, Puerto ecity:	ecify Yes or No Rican, etc.)	Spe	lace - Americ Black, White, c <i>ify:</i> Wh	
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lary	2 sho and N Is ma	ľ	19a. Informant's Nan	ne/Relationship (Type, Print)		19b. Mailin	ng Address (Street and N	lumber or Rura	al Route Numb	er, City or Tov	vn, State, Zip	Code)
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Riddle, altimore, N	t. Pages riment of t riant: if ite		4 Donation 5	Cremation 3 Other (Specify	1)	ale	Place of Dispo emetery, cren Cro Cre	mator	у	4-17	-2006		more,	
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68760,	Physician // Medical Examiner but sthe prival-transit	edical Examiner	Immediate Cause (F disease or condition resulting in death) Sequentially list containing to immediate Cause. Enter Underhocause (Disease or in that initiated events resulting in death) La	bitions, nediate ying jury	a. Due to (or Due to (or c.		uence of): uence of):	, RE	NAL	CEL	L CAT	2 C(NC	mA	Interval Between Onset and Death
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sion of	ending Physath. or: After this he funeral di	atlon; To	1 Yes 2 7. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of (Month,		ER/Outpatient 28b. Time of Injury		injury at Work?	2	ne 5 ☐ Resid 28d. Describe i			<i>ı</i>)
Divis	tal or Att rs after de el Direct ed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of	f Injury - At ho , etc. <i>(Specif</i> y	me, farm, stre	eet, factory,	office	2	28f. Location (: City or Tox		nber or Rura	l Route Number,
	the Hospi in 24 hour the Funer pletely fill	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	ysician: To the be liner: On the bas and manne	is of examinat	wledge, death ion and/or inv	occurred at estigation, is	the time, da n my opinion	te and place, a , death occurre	and due to the ed at the time,	cause(s) and a	manner as st e, and due to	ated. the cause(s)
	with To Con	2	29b. Signature and tit	me g by	ú			Do		824			L 16	14,2006
			30. Name and addres		_				116-1	in me	OCTR	CLE	N BU	RME NO
	Sta Registr		31. Date filed (Month,	PR 1 9 2	2006	istrar's Signal	& A	ode		44.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink

State of Maryland	/ Department			Hygien
	Certificate	of Death		

lo.	2	Û	0	6	No.	Ĺ	property com	7	6
				2	Timo	of Do	oth		

2321 hrs

Death

Reg. N

2. Date of Death

Month Day April 11, 2006

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho l other than "r the Medical E njury or other

æ

William C. Cotton

Donnetta Scott/Daughter 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State

19a. Informant's Name/Relationship (Type, Print)

Donation 5 Other Specify:

21. Signature of Funeral Service Licensee

	Physician	23a. Part . Enter the disease, of failure. List only one cause	or complications that caused the deat		dying, such as cardiac of					
-	/Medical xaminer	Immediate Cause (Final diseas	0 1 1 1 11 11 15 15	rrhage						
	xammer	or condition resulting in death)	Due to (or as a consequence	of):						
		Sequentially list conditions,	b. Ruptured gastroesoph	ageal varices						
	je je	if any, leading to immediate	Due to (or as a consequence	of):						
		cause. Enter Underlying Cause (Disease or injury that initiated	C. On mosis of the neel							
	red Insit	events resulting in death) Last		Of):						
	and and tran		d							
	be ex ician urial	UNPENDED	AMENDED							
OX 68760 eath certificate be attending physi	Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit pedical Contribution. To Re Commissed by Physician/Medical Expedical Contribution.	UNPENDED AMENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								
	O. Bo nat the dee d by the a etached fe	Part II. Other significant cond	itions contributing to death but not	resulting in the underlying	cause given in Part I.	23e. Did tob	acco use co	ntribute to		
	ires that signed a be deta	1 Yes								
ecords he law requi	Division of Vital Records, lat or Attending Physician: The law require as fair death. In Director: After this certificate has been signed in by the funeral director, page 2 should by artification. To Re Commisted.	24a. Was an autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Ye								
	an: an: entificator,	25. Was case referred to medical 26. Place of Death (Check only one)								
	f Vita Physicia or this ce ral direc		Hospital: 1	P ER/Outpatient 3 DO	OA Other Nursi	ng Home 5 R	esidence (6 Other		
	ion of ttending P leath. tor: After the funera	27. Manner of Death 1 Natural 5 Per 2 Accident Invi	28a Date of Injury (Month, Day, Year) anding estigation	28b. Time of Injury 2	8c. Injury at Work? 1 Yes 2 No	28d. Describe ho	w injury occ	urred		
	Division of spital or Attending from a first death. neral Director: After filled in by the funer funer funer funer funer for the funer fu	3 Suicide 6 Cou		home, farm, street, factory,	office building, etc.	28f Location (Str or Town, Sta		mber or Ru		
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 bours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		Physician: To the best of my knowle aminer: On the basis of examination and manner stated.							
	- 3 - 3 2	29b Signature and title of certif	ier ()	29c.	License number		29d. Date s	igned (Moi		
1		Potu U	ionic-18	llen	O.C.M.E.		April 12,	2006		
	CR (3)	 Name and address of person Patricia Aronica-Polla 	n who completed cause of death (Ite ak MD. Assistant Medical	,	nn Street, Baltimo	re, MD 21201				
	Stat	31. Date filed (Month, Day, Year								
	Registra									
	HMH 17 Rev 1/2001	AFRZU	2000 /	ORIGINAL						

4b. City, Town, or Location of Death 4c. County of Death Prince George's County Hospital Cheverly Prince George's If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours 08/23/1957 577-80-2854 1 XM 2 F 48 Wash. DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Y Yes 2 No Hyattsville Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6214 Osborne Road 20785 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Married Yes Black. Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Specify or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) Electrical Engineer Government 12th

> Nettie L. Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18.Mother's Name (First, Middle, Maiden Surname)

Wash., DC 20032 1355 Congress St., SE

20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Harmony Memorial Park 4/18/2006 Landover, MD Stewart Funeral Home

4001 Renning Rd DC 20019 Approximate Interval Between Onset and

> e to the cause of death? Probably 4 Unknown

Day

autopsy findings available to completion of cause of 2 No Yes

Rural Route Number, City

started o the cause(s)

(Month, Day. Year)

			1- For State of Maryland / Department of Horizontal Certificate of L		ental Hygie	ZUUn -	14173
п	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Abdullah Siddiq		4/17/	2006	12:20p
	Examir	ner	G 1 -1	Location of Death		4c. County of Death	
			St. Thomas More Nursing Center Hyattsv 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	9. Date of Birth	Prince	
	Funeral Director		577-52-9928 1월м 2□F 67 Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 1 / 8 / 1 9 3		place (State or Foreign intry)
			Usual Residence of Decedent	<u> </u>	1/0/193	was	hington
	anylan show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-1	scto	D.C. Washington				1 ☐ Yes 2 No
	with ti	Ö	10e. Street and Number 10f. Zip Code			Citizen of What Cou	intry?
	eath is 23	erai	5010 A St., S.E. #104 20020 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His			.S.A.	inna tadina
10	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Never Married 2 ☐ Married 1 ★ Never Married 2 ☐ Married	n, Mexican, Puerto F	Rican, etc.)	14. Race - Amer Black, White	, etc.
936	urs a al', or	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specify: bla	ack
5-0	72 hours 'natural',	Completed	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done december of the complete	ation	16b	. Kind of Business/li	ndustry
7	d within 7. piene.	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired))	19		
2	filed w Hygien other ther		12 unemployed	40 Maria de Nasa		none	
and	ould be f Mental H arked ot atic ever	Be	Richard E. Strange	18. Mother's Name Alma		liams	
Maryland 21215-0036	2 should be and Mental is marked a sumatic ev	To	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street au</i>				n Codel
	es 1 and of Health fitem 27 r other tr		Tywanna Means- Sister 3547 13th St				
Baltimore,			20a. Method of Disposition 20b. Place of Disposition (Name of	Di	4.77	. Location - City or T	
Ë			1 ■ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) All Muslim Ceme		0/06 st	afford,	VA
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Jicensee 4 21. 1 22. Name and Address	s of Facility Un			
_	89 5 8		411 Kenne	edy St.,	N.W. Wa		DC 20011
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dispase	Approximate Interval Between Onset and Death		
ox 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			23d. Date of deliv	an.
.O. Box	that the death led by the atter detached for u	hysiciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	ery Day Year
rds, P	The taw requires that the tee has been signed by the bage 2 should be detached.	Completed by P	Part II, Other significant conditions contributing to death but not resulting in the underlying cause giver	o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Offichown			
Vital Record	as be 2 sho	ple	Encepha Lopathy		24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
H		Con	Diabetes Miellitis		performed 1 ☐ Yes 2 🔀	? death?	2 No
/ita	hysician: The law his certificate has b I director, page 2 s	Be	examiner?	26. Place of Death	(Check only one)		
of	Physician: this certificated director,	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	4 Nursing Hom		6 ☐Other (Special	(y)
UC	ding T. After fune	ion	27. Manner of Death 28a. Date of Injury 28b. Time of Section 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation M 1 ↑ Y	at 21 ? ′es 2 ⊡No	8d. Describe how in	njury occurred	
Division	or Attending after death. Director: After in by the funer	ertification;	3 Suicide 6 Could not be date mined		8f. Location (Street	and Number or Rura	al Route Number,
ā	tal or A	Cert	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License	number	29d. I	Date signed (Month,	Day, Year)
\wedge	(1)		Sunllinglika 100	1152	- /	14121	4006
	6		30. Name and address of person who completed cause of death (Item 23a) (Type) Print) POULA, DEVARE MA 420 (Vyel) 31. Date filed (Month Pay Year) Beginger's Signature	my Pdt	1yatta	illemi	20181
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 0 2006				

			1 - For State Registrar	State of Ma	ryland			nt of Ho te of E		nd M	_	giene Reg. No.	16	14174
İ	Physici		1. Decedent's Name (First, Middle, Last Coscealia A. Sa								2 Date of De April	ath	2ď06	3. Time of Death 0245 M
1	/Medic Examin		4a. Facility Name (If not institution, give	,			4b. City, Town, or Location of Death					y of Death	7 -	
3.	Funcial		Anne Arundel Me 5. Social Security Number 6. Se			st birthday)		apol	. 1 S If Under 2	4 Hrs.	8. Date of Bird		Arur 9 Birthol	ICE L
	 Funeral Director 		,	M XF		3 Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da Dec 18	y, Year) 3 1942	W. V	rginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation						10	0d. Inside City Limits
	Maryl	Į.	Maryland Anne Ar	undel		apol								₩ es 2 No
	or 289	Oirec	10e. Street and Number				10f. Zi	p Code				10g. Citizen of	What Coun	try?
	e 23a	Funeral Directo	643 Bywater Rd.	12 Was Decedes S	in II C	10.11	V D	2140		-2 (0-	N	US		
326	2 hours after death with the Maryland atural; or Iteme 23a or 28a-1 ehow cal Expenies must be notified at	þ	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		11	Yes, spe	cify Cubar	Specify:	in? (Spe Puerto i	cify Yes or No Rican, etc.)	Bla	ce - America ck, White, e fy: B1 a	etc.
215-0036	72 hours 'natural', dical Exe	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of we	ork done di	irina most	of workir	na	16b. Kind of E	Business/Ind	lustry
121	within 72 ene. than "na	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5	+)	life. D	ashi	ise retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or works	.9	WaW	2	
7	Hygi other	Be Co	12th 17. Father's Name (First, Middle, Last)	2yrs			ABIL		18. Mother	's Name	(First, Middle,	Maiden Suma		
yiand	2 should be and Mental Is marked o	ToB	Larry Biggers					Į	ucin	der	Price	<u> </u>		
Man	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (Ty									r, City or Town		•
d)	of Health item 27 other tr		Beverly S. Saund 20a. Method of Disposition	ers(Husc	20b. Pla	ce of Dispos	sition (Na	me of			napol:	20c. Location		
Ē	Pages nent of int: If i		1 A Buriat 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		ne <i>tery, cr</i> em 'ylan				-19	-06	crowns.	ville	, Md.
Baitimore,	permit. Pages 1 Depertment of H Important: If ite eny Injury or ot once.		21. Signature of Funeral Service Licens		7004	82 83	Name a M R	Address eese	of Eacility	ons	Morti	ary,	P.A.) 1
K,			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused	the death.									Approximate Interval Between
	Physician /Medical	3	Immediate Cause (Final disease or condition resulting in death)		EMIC		EAR	Ti)15E	ASE	-			Onset and Death
	Examiner			Due to (or as a	conseque	ince of):								
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	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):								
α/ρΩ'	icate be executed physician and s the burial-translt	dicalE		1	. 551135450									
0		00 1	IF FEMALE:											
מס	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal d	eath 3 🗌	Ectopic p						ate of deliver	ry Day Year
j.	the de ny the a	ysic	1 □ Yes 2 🛣 No 9 □ Unknown	4☐Pregnant at 1 9☐ Unknown	time of dea	tn 5	Other (sp	овсту)						,
ρ. Σ	requires that the een signed by th hould be detache	by Pi	Part II. Other significant conditions con	ntnbuting to death bu	t not resulti	ing in the un	derlying	ause giver	n in Part I.		23e. Did to	bacco use con	tribute to the	e cause of death?
ecords	een si		HYPERTEA	SIVE (· AL	-1210	my	2497	HI		1)2	es 2□No	3 Proba	ably 4 Unknown
Hec	has b	Completed									24a. Was autop		Were autop prior to corr death?	sy findings available apletion of cause of
Vital	an: The	0	25. Was case reterred to medical				•		26 Place	of Death	1 ☐ Yes	2 10	1 ☐ Yes	25 No
- N	hysici his cer I direc	To B	examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 🗌 Inpatier	nt 2 EF	R/Outpatient	3□ D0	Othor	-		-	lence 6 🗆 Oti	ner (Specify,)
פיים	ling Pi		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury		28c. Injury Work	•		8d. Describe h	ow intury occur	rred	
UNISION	death death ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hom	e, farm, stre	M et. factor		9s 2 □ N		8t. Location (5	Street and Num	ber or Rural	Route Number.
É	s after s after al Dire	Certi	4 Homicide determined	building, etc.	.´(Specify)			,,			City or Tox			,
	To the Hospitel or Attending Physician: The law within 24 bours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 to	edical	29a. Certifier 1 Certifying Physical Certifying Physical Certifying Physical Exami	sician: To the best oner: On the basis of and manner state	examination	edge, death n and/or inv	occurred	at the time i, in my opi	, date and nion, death	place, a occurre	nd due to the old at the time, o	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
	withi To th	Ř	29b. Signature and title of certifier				29	C. License	number			29d. Date signe		Day, Year)
			/www.					リみい	1 /40	5		1.17.0	06	
			30. Name and address of person who co	277 Pini	ath (Item 2	Farm	rint) Rd.	Aco	old, M	d. 2	21012			
2.5	Sta		31. Date filed (Month, Day, Year)	32. Figgistra	r's Signatur		mall	<u> </u>	-1-1/-1	4.				
	Registr	ar	APR 1 9 2	UUOI A	17	13 633	U. C.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April 18, **Physician** Fred W. Schulte 2006 2:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Britton Woods Nursing Home Winfield Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 24, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F **Funeral** Months Days Yrs. 86 Ĭndiana Director 308-14-0109 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County other then "naturel", or items 23s or 28s-f ehow 1 ☐ Yes 2 X No Director Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Buffalo Road 21771 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: WWII White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Farm Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event ang injury or other traumatic event Be Henry Schulte Maude Walker ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Buffalo Road Mt. Airy, MD 21771 Christel Schulte Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery Mt. Airy, MD 4 Donathon 5 Other (Specify) 21. Sign Funeral Service J Burrier-Oueen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 3a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shield, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm sate Cause (Final disease or condition sulting in death) diarea Physician 3 many 0 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ne 24a. Was an autopsy performed? certificete 1 Yes 2 3 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending i ofter death.

i Director: Afted in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital o within 24 hours eft To the Funersi Di completely fitted in 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year) 20806 WILIK 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URNUSUAD 1000

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2

1 2008

ORIGINAL

32. Registrar's Signature

		•	For State Registrar	State of	Maryland		artment of tificate of				iene og. No.	06	4176
	Dhyciai		1. Decedent's Name (First, Midd	lle, Last)					2.	Date of Deat Month	h D ay	Year	3. Time of Death
	Physicia /Medic	al .	WILLIAM A. SHERRANE APRIL 19 2006								12:33 A ^M		
	Examin	er	4a. Facility Name (If not institution				4b. City, Town,		of Death			unty of Death	
			CHESTER RIVER 5. Social Security Number	+	7. Age (In yrs. Ia	st hirthday)	CHESTE If Under 1 Yea		24 Hrs. 8	Date of Birth	KE		place (State or Foreign
	Funeral Director		142-38-3309	1 ∑ M 2□F	58	Yrs.	Months Day		Min.	(Month, Day, EPT • 19		Cour	
			Usual Residence of Decedent								,		
	irylan show	-	10a. State 10b. County	y	10c. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f.	octo		EN ANNE'S	CEN	TREVI					0- 01	of What Cour	
	with th	듬	10e. Street and Number				10f. Zip Code			''		TOT WITAL COUR	ntry :
	18 234	erai	205 ARMSTRONG 11. Marital Status		dent Ever in U.S	13.	2161 Was Decedent of		igin? (Specif	v Yes or No-	USA 14.	Race - Americ	can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It man 27 is marked othar than "natural", or items 23a or 28s-f show other traumatic evant, the Medical Exement must be notified at	by Funeral Director	1 Never Married 2 Mail 3 Widowed 4 Miloroce	rried Armed For	ces? 2 [] No e		f Yes, specify Cu 1 ☐ Yes 2 🔣 N	ıban, Mexica	n, Puerto Ric	án, etc.)	Sp	Black, White, ecify:	etc. HITE
21215-0036	2 hou	ted		nt's Education		16a. Dece	dent's Usual Occ	upation	et of working		16b. Kind	of Business/In	dustry
215	within 7 iene. than "n	pie	(Specify only night	est grade completed) College (1	-4or 5+)	life.	kind of work don DO NOT use reti	red)	St Of WORKING				
	e filed within al Hygiene. I othar than ' vant, the Me	Completed		4		REAL	ESTATE					ESTAT	<u> </u>
Maryland	be fill ntal Hy od oth	Be	17. Father's Name (First, Middle						·	First, Middle, I	иаіаеп Su.	тате)	
3	should be ind Mental marked umatic ev	P	HERBERT B. SHI 19a. Informant's Name/Relation			19h Maili	ng Address (Stre		NRIETT		City or To	own. State. Zir	Code)
Ma	nd 2 salth an 27 is 1		RICHARD SHERRA				MAGNOLI						
	s 1 and Heal		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of	lace)	Date	9	20c. Locat	ion - City or To	own, State
9	Pages ent of nt: if ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State CHES	SAPEAI	natory or other p CE CREMA	TORY	04/20/2	2006	STEVE	NSVILLI	E, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once.		21. Signature of Funeral Service	Licensee Selfen	bein		Name and Add ELLOWS, SO SPEER						HOME, P.A.
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cast only one cause on a	aused the death.								Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequence of):										
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury										
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	be executed sician and burial-transit	xan	that initiated events c							-			
8760,	death certificate be executed e attending physician and of for use as the burial-transit			d									
9	ifficate g phy as the	Physiclan/Medical								-		- 111	
Вох	eath certifica attending ph	M/us	IF FEMALE: 23b. Was decedent pregnant	ncy death 3[Ectopic pregnar	ncv			230	23d. Date of delivery Month Day Year			
	death	sick	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de		Other (specify)					MOHEN	Day real
P.0	that the de ed by the detached	Phy	9 Unknown	tions contributing to do	ath but not recu	Iting is the I	indorhina causa	awen in Part		23e Did to	d tobacco use contribute to the cause of death?		
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oro	w requir been si should	etec	U 400		· · · · · · · · · · · · · · · · · · ·					24a. Was a	10 13	24h Were aut	opsy findings available
3ec	9 4 9	Completed	2 11/14							autops perfori	sy med?	prior to co death?	ompletion of cause of
a		e Co	25. Was case referred to medic	eal .				26 Plac	se of Death //	1 ☐ Yes Check only or	2 N6	1 🗆 Yes	2 No
5		0 B	examiner?	Hospital:	npatient 2 VE	RV utpatie	nt 3 DOA	Other				Other (Speci	fv)
of	g Phys er this eral di		27. Man or of Death	28a. Date		28b. Time o			-	d. Describe h			
ion	Attanding ir death. actor: After by the funer	atio	Natural 5 Pend 2 Accident inves	ling (Morn stigation	n, bay roar	injury		Yes 2]No				
Division of Vital Records,	i or Attanc after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 288. Place	of Injury - At hor ng, etc. (Specify,	me, farm, st	reet, factory, offic	се	281	f. Location (Si City or Town	treet and M n, State)	lumber or Rur	al Route Number,
	ital or urs afte ral Dir												
	Hospital	edical	29a. Certifier 1 Certify (Check only 2 Medical	ring Physician: To the at Examiner: On the ba	best of my knov asis of examinati ner stated.	vledge, dea ion and/or ir	th occurred at the ivestigation, in m	y opinion, de	ath occurred	at the time, d	ause(s) ar late and pl	ace, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Med	29b. Signature and title of certif				1	ense number		2	29d. Date s	signed (Month,	, Day, Year)
1))		0.60	rare			DO	00616	58		04	11910	6
0	L/		30. Name and address of person		se of death (Item	23а) (Туре	Print)	/ 4:		15 0	11 10		
9	ratio		Lipal R.De		8 DIDO	nat	Drive	UNUT	as N	ND 2	1619		
		ate	31. Date filed (Month, Day, Yea		egistrar Signat	ture A	Drive	50					
	Regist	rai	AP	R 2 0 2006	A CONTRACTOR	المنافق المسا		Marie					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** HORIL VINCENT HECTOR STELLATO 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death . 4b. City, Town, or Location of Death Examiner Micomica 5,446% REGINAL MEDICAL PONINSIKA Onder 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1⊠M 2□F Months Hours MASSACHUSETTS 88 034-05-6371 Director Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County other than "naturel", or Itame 23a or 28a-f show vent, the Madical Examiner must be multied at 1√2 Yes 2 □ No WICOMICO SALISBURY Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 205 S. BROOKDALE DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1934- Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE tf Yes, Give Year or Dates: δ 1937 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Elementary/Secondary (0-12) OWNER OPERATOR RETAIL 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 9DRB. UNKNOWN UNKNOWN STELLATO UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10711 RIVERTON ROAD, MARDELA SPRINGS, MARYLAND 21837 CAROLYN DAWSON - FRIEND Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SPRINGHILL MEM.GDNS. 04-24-2006 HEBRON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a, Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 10 DA41 **Physician** /Medical Due to (or as a consequence of): OBSTRUCTIVE LUNG DISEASE 6 YEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Il or Attending Physician: The law requires thet the death cartificate be executed effer death.

Director: After this cartificate has been signed by the attunding physicien and din by the tuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records. P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by FIBRILLATION 1 res 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours e To the Funeral C completely filled in nertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) ADRIL 19, 2006 6962 29b. Signature and title of certifier John 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RE GIONAL MEDICAL CENTER, MD 21081 M. SHIRAZI, M.D. PENINSULA 100 E. CARROLL STREET SHISBURY Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Soul Registrar

06-02552 Kaitlyn Smith

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar	Certificate of	Death		Re	g. No.	6 141/0		
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death 0825 hrs		
ledical Exami	ner	Kaitlyn Ann Smith 4a. Facility Name (if not institution, give street and number)	14	b City Town o	r Location of Dea	April 15, 20	4c. County of De			
		St. Agnes Hospital		Baltimore			Howard			
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Ye			h(MM/DD/YYYY) 9.	Birthplace (State or		
Director		232-53-1776 1 M 2XXF	Yrs.	Months Da 21	ys Hours M	July 2	21,2005	reign Country) W		
ý		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location	200				10d. Inside City Limits		
ow any			Mathias	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				1 Yes 2 X No		
Aaryland 28a-f show 1 at once.	ctor	W Hardy 10e. Street and Number	гишиз	10f. Zip Code		10	g. Citizen of What C			
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Director	2347 Strawderman Rd.		2	26812		USA			
with 1 ms 23.2 be not	eral	11. Marital Status 12. Was Decedent Ever			ispanic Origin? (an, Mexican, Pue	Specify Yes or No-	14 Race - An White, etc	nerican Indian, Black,		
or ite	Fun	X Never Married 2 Married 1 Yes 2XX	No			no Rican, etc.)				
rs afte	2	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete		Yes 2 X N	o specify: ation (Give kind o	of work done	Specify: 16b. Kind of Busine:	White ss/Industry		
72 hou 1 "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)			e. DO NOT use r			,		
036 vithin 72 ene. rr than '	Comple	0	N	Α			NA			
15-00; filed withi Hygiene d other ti , the Med		17. Father's Name (First, Middle, Last)				me (First, Middle, N tina Buc l		=00-30-		
AD 21215-0036 2 should be filed within 72 n and Mental Hygiene. 27 is marked other than " imatic event, the Medical	o Be	Robert Smith Sr. 19a Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stre			ber, City or Town, St	ate, Zip Code)		
, MD 2 and 2 shou ealth and N em 27 is n		Robert Smith Sr.					ias, WV 26			
ore, Mes I and 2 of Health If item 2		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State	20b. Place of Disposit crematory or other			Date /20/06	20c. Location - City	or Town, State		
Pages nent of ant: I		4 Donation 5 Other Specify	Cullers C	emetery	/	/20/06	Mathias			
Baltimore, permit Pages 1 at Department of Hee Important: If ite		21. Signature of Funeral Service Licensee		ame and Addre			eral Home	LLC		
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/Medical		fillure. List only one cause on each line. Between Onset and Death								
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760, ficate be executed g physician and the burial - transi	/Med	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d Date of deliv	very		
	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time	of double		Ectopic pre	gnancy	Month	Day Year		
Box 68's death certificate attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	of death 5 Oth	ner (Specify)						
P.O. Bc that the de- med by the a detached fr		Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause	given in Part I.	23e. Did to	bacco us a contribute	to the cause of death?		
ires that resigned by	d by					1 Yes		Probably 4 V Unknown		
ords, w requir as been s should	Completed					24a. Was autop	sy prior	autopsy findings available to completion of cause of		
Recort The la	omi					1 V Yes	med? death 2 No 1 ✓	pro		
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Division of Vital Records, tat or Attending Physician: The law requirist death of Attending Physician: The law requirist death of Birrector: After this certificate has been sited in by the funeral director, page 2 should be	ဥ	1 Yes 2 No Inpatient 27 Manner of Death 28a Date of Injury	2 ER/Outpatient 28b. Time of In		jury at Work?		Residence 6 0	ther:		
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/iSiC r Atte ter dea irecto	ficat	2 Accident Investigation	- At home, farm, stree			. 1	Street and Number or	Rural Route Number, City		
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To with	Mec	29b. Signature and title of certifier			nse number		29d Date signed (
		higher, must		0.0	C.M.E.		April 16, 2006			
		30. Name and address of person who completed cause of death		• Delkisser	MD 21201					
	toto	Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's S	ionature		, IVID 2 12U1					
S Regis	tate trar	MAY A 9 2001 E.	10	seles						

		State of Maryland / Depa		-		
		, FOI	tificate of Death		2006	141/9
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physicia /Medic		Mary Ellen Stoddard		April 12		1:40P M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arund	
Funeral Director		198–16–2328 1 M XXF 81 Yrs.	Months Days Hours Min.	(Month, Day, Y	924 Penr	place (State or Foreign htry) ISylvania
		Usual Residence of Decedent				*
arylar ehow	Ž	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 2 🕏 No
the M	Director	Maryland Calvert Prince F	rederick	100	. Citizen of What Cour	
3a or	ū					,
death	Funeral	420 W. Dares Beach Road #408 11, Marital Status 12. Was Decedent Ever in U.S. 13. Varied Forces?	20678 Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	USA 14. Race - Americ Black, White,	
or Ite	y Fu	1 Never Married 2 Married 1 Yes 2 XNo	Tes, specify cuban, Mexican, Fuelic	riicari, etc.)	Specify:	etc.
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d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Cash	Office Manager	1	ept. Store	2
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Healt Healt tem 2					c. Location - City or To	own, State
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permit. Pages 1 and 2 Department of Health s Importent: If item 27 is any injury or other tre			. Name and Address of Facility Geo	. P. Kala	as Funeral	Home
Dermi Depa Impo any i		Sup f. Kallo, fr	973 Solomons Isla	nd Rd. Ed	lgewater,ML	21037
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ne faw has b	ompleted			24a. Was an autopsy performe	d? prior to co death?	psy findings available mpletion of cause of
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ysicie s cert direct	0	examiner? 1 Yes 2 60 Hospital: Dipatient 2 ER/Outpatien	Other		e 6 ☐Other (Specifi	y)
neral	T iuc	27. Manner of Death 1	28c. Injury at Work?	28d. Describe how	injury occurred	
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or Att	Certification;	4 Homicide 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	City or Town, 5	et and Number or Rura State)	il Houte Number,
To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. When the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death				
ne Ho n 24 the ne Fu	Medical	(Check only and nature) A Nedical Examiner: On the basis of examination and/or invariant nature stated.	estigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
To the within To the comp	Σ	29b. Signature and the of certifier	29c. License number	29d	Date signed (Month,	Day, Year)
		Myles	עון נצויוט	7	119/2006	
		30. Name and address of person who completed cause of death (Item 23a) Type.	Print) AR mule	Redo	al cent	E
Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature				
Registr	ar	APR 17 2006				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 April 14, **Physician** Augustine Sampogna 12:53 p M Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Feb. 7, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1**™** M 2□ F Yrs. 1915 91 Washington, 579-01-6570 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ahov artment of Health and Mental Hygiene. ortant (If Item 27 is marked other than "natural", or items 23s or 28s-1 sho injury orginer traumatic avant, the Modical Examinar must be notilised at 1 ☐ Yes 2 X No Directo Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 3616 Littledale Road USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates: 1942-46 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 28 No Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Financial Management Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be it. Pages 1 and 2 should be introduced to Health and Mental intent (If Item 27 Is marked o Anna Maria Gianantonio Domenico Sampogna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28329 Canterbury Drive, Salisbury, MD 21801 Robert Carter/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition April 19, 1 TBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 Departr Departr Imports any inju 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Congestive Heart Failure and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□ Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Arthritis, Chronic Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown beer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No certificete 1 🗆 Yes of Vital director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖾 EP/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Division Injury 1 Natural 5 Pending To the Hospite to recommend to the Funeral Director: At To the Funeral Director: At recommend to the further than the further 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D53691 April 17,2006 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6320 Democracy Blvd, Bethesda, MD 20817 Ajay Reddy, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 19 2006 Registrar

Dhyci	oian	1 - For State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of De	ath	Reg.	No.	3. Time of Death
Physi /Med Exam	lical	4a. Facility Name (If not institution, give s Anne Arundel Med		4b. City, Town, or Loc	.s		4c. County of Dea Anne Ar	undel
Funera Directo		Usual Residence of Decedent	M 2/2LF 86 Yrs	Months Days Ho	ours Min. 3 U	Date of Birth (Month, Day, Ye 11y 24		thplace (State or Foreign puntry) ryland
death with the Maryland ma 23s or 28s-f show rmust be notified at	ector	Maryland Anne Ar	undel Annapo			100	Citizen of What Co	10d. Inside City Limits 12 Yes 2 No
h with t	ai Dir	10e. Street and Number 2026 Forest Dr.		21401		109.	USA	Sunity :
urs after deal	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:	13. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 🏋 No St	nic Origin? (Specify exican, Puerto Ric pecify:	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	te, etc
be filed within 72 hours after death with the Marylar ital Hygiene. other then "naturel", or itema 23a or 28a-f show other then "naturel", or itema 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 12th	cation completed) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during le. DO NOT use retired)	g most of working		Kind of Business	
	To Be C	John Eades		E	Mother's Name (F mma Jen	nings		
s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) Phillip E. Hill		Mailing Address <i>(Street and I</i> 26 Forest D				
Page ient o nt: #		20a. Method of Disposition 1 A Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	Brnovai from State	isposition (<i>Name of</i> crematory or other place) and Veteran	4-20-		Location - City or	
permit. Deportm Importa any inju	and a	21. Signature of Funeral Service License	es MOOY83	Wm. Reese of 821 West S	& Sons t. Anna	Mortua:	ry, P.A Md. 21	401
Physiciai /Medica		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not e cause on each line.	enter the mode of dying, su			ilus	Approximate Interval Between Onset and Death
Examine	Examiner		Due to (or as a consequence of) Due to (or as a consequence of)	odial	rifo	anti		2 pon
e death certificate he attending phys led for use as the	by Physician/Medical		3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year
w requires that the been signed by t should be detach			tributing to death but not resulting in the	ne underlying cause given in	Part I.	23e. Did tobaco	0	o the cause of death? robably 4 Unknown
The ate ha	Completed					24a. Was an autopsy performes 1 Tes 221	? prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
	o Be	examiner?	ospital: 1 Unpatient 2 ☐ ER/Outpa	Other	Place of Death C		a 6 ∏Other (Spe	acify)
gr en		The second secon	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Injury at Work?		d. Describe how i		Joney
oital or Attending urs after death. oral Director: Afte	Certification:		28e. Place of Injury - At home, farm building, etc. (Specify)			City or Town, S	tate)	tural Route Number,
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examination	sician: To the best of my knowledge, of the basis of examination and/of and manner stated.	death occurred at the time, do or investigation, in my opinio	late and place, and in, death occurred	due to the cause at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To the To the Comp	W	29b. Signature and title of certifier	xfexta m	29c. License nui	21438	^{29d.}	Date signed (Mon	th, Day, Year) 12, 2006
		30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty	YPO, Print DEFEN	SE His	hway	ANNAPO	145MD21401

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 rdon /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nde 6. Sex redina 7. Age (In yrs. last birthday) Milloder 1 Vear If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 889 Months Days 10M 20 F 21258-Director 0 MD Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylei Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at MD 1 ☐ Yes 2 ☑ No Anne Arundel Arnold Director 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1215 Julie Court Funeral 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give 1X Never Married 2 ☐ Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Asst. V.P. - Branch Manager Banking 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur George Ueberroth Frances Joan Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ueberroth/Sister 1215 Julie Court, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr.13, Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funerel Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List Physician Immediate cause (Final disease condition resulting in death) rivicaical week Examiner Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to for as a consequence of: resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home P 2 No 1 Tes 5 ■Residence 6 □Other (Specify) this 28c. Injury at Work? 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certlflcation: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No efter death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hosp... within 24 hours efter The Funeral D' edical 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2002

gistrar's Signatur

Medica

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 9 2006

32.

State

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death April 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2006 4:15P. Valery Maricela Vasquez 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year)
April 27,2006 Maryland If Under 1 Year | II Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 💢 F none Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 📉 No Maryland Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20708 10110 Madronawood Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1X Yes 2□ No Hispanic El Salvadorian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Heidi Velasco Romulo Vasquez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Romulo Vasquez -father 10110 Madronawood Drive Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State MD Natnl. Mem. Park 4/29/2006 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dönald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medical Examiner

burial-transit

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28e-f ehow Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene important: if Item 27 is marked other then "natural", or Items 23a eny injury or other traumatic event, the Madical Examiner masses once.

Baltimore, Maryland 21215-0036

Director

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Completed

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icate has been sig , page 2 should b After this certificate funeral director, pag To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition	Severe I	Prematurity					ninutes
resulting in death)	Due to (or as a consec	quence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quaries of):					
that initiated events resulting in death) Last	C. Due to (or as a consec						
	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3 ⊟Ectopic pi			23d. Date of de Month	əlivəry Day	Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying c	ause given in Part I.		couse contribute 2. XNo 3 □ F		e of death?
				24a. Was an autopsy performed 1 ☐ Yes 2X	prior to death?	completion	lings available of cause of
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)			
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ DC	OA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Sp	ecify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) on		Bc. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how i	njury occurred		
3 ☐ Suicide 6 eould not 4 ☐ Homicide determine		nome, farm, street, lactor	/, office	281. Location (Stree City or Town, S		Rural Route	Number,
29a. Certifier (Checkony one) 2 Medical Exe	nysician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner a and place, and du	as stated. ue to the ca	use(s)
29b. Signature and title certifier	K	290	c. License number	29d.	Date signed (Mor	nth, Day, Ye	ar)
1/oce	7	I	31265	A	pril 27,	2006	

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)
Imad S. Mufarrij, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910

32. Registrar's Signature

4 2006

		-	FOR	partment of Health and N ertificate of Death	lental Hygien	UUD 14104
	m 31 g		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Philip Michael Vellon		April 17,	^{ay} 2006 Year 10:35 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
1		96	Anne Arundel Medical Center	Annapolis	I	Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 □ XM 2 □ F 7. Age (In yrs. last birthdi	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 2, 19	9. Birthplace (State or Foreign Country) New York
	20		Usual Residence of Decedent			
	ylan		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 22 No
	a-f s	cto	NY Ulster Marlbo	ro		1 1 785 24 <u>5</u> NO
	or 28	Oire	10e, Street and Number	10f. Zip Code		itizen of What Country?
	23a	rai	167 Highland Ave.	12542		SA
926	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Department of Health and Mental hygiene important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avant, if a Madical Exercitical minal te rotilited at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 \(\overline{\text{No}} \) Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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land	ld be fill ental Hy ked oth ic avant	To Be	17. Father's Name (First, Middle, Last) Anthony Vellon	18. Mother's Nam Elizabe	e (First, Middle, Maide th Mack	an Sumame)
Mary	nd 2 shou Ith and M 27 is mar		, , , , , ,	Highland Ave. Ma:	al Route Number, City	
Baltimore, Maryland 21215-0036	Pages 1 arent of Hea		1 ABurial 2 Cremation 3 Removal from State	sposition (Name of trematory or other place) y's Cemetery 04/22		Location - City or Town, State
Baltii	permit. F Departmo importar any injur	Ì	21. Signature of Funeral Service Licenses	22. Name and Address of Facility Roll 16000 Annapolis Ro	oert E. Ev	ans Funeral Home
	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or complications that caused the death. Do not			Approximate Interval Between
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_,	ate be executed hysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (Fras a consequence of):	3102		
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of Vital Records,		Completed			24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
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<u>></u>	hysici this cer al direct	၉	1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpa			6 ☐Other (Specify)
			27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1. Natural 5 Pending	y Work?	28d. Describe how in	jury occurred
Sio	Attendii death. ctor: A y the fu	cati	2 Accident investigation	M 1 Tes 2 No	721 1 1 1 1 1 1 1 1	and Number or Rural Route Number,
Division	ospitai or Attendours after deatl hours after deatl uneral Director: ly filled in by the	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	City or Town, Sta	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not be the past of examination and/of and manner stated.			
)	To th To th	M	29b. Signature and title of certifier Deput Deput	29c. License number D0605	29d. [Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty William P. Jones, MJ	pe, Print) 29c. License number DOGO 5 pe, Print) 695 Amo	erica	21035
	Sta Regist		31. Date liled (Month, Day, Year) APR 1 9 2006 32 Registrar's Signature	book		

			1 - State 4-20-06 Registrar Amend# 23a.Pi	State of M	arylan	d / Depa	artmę		ealth an		ental Hyg	_	06	14185
24	Physici		Decedent's Name (First, Middle, Last Gonza			White					2. Date of Dea Ap M1I th 12,		Year	3. Time of Death 12:20 A M
	/Medic Examir		4a. Facility Name (If not institution, given Ft. Washington Hospi				4b. Cil	y, Town, or Washi	Location of C ngton	Death		4c. Coun Prince	ty of Death e Georg	e's
	Funeral Director		201 00 0247		e (In yrs. 62	last birthday) Yrs.	If Und Month	er 1 Year S Days	If Under 24 Hours	Hrs. Min.	8. Date of Birth (Month, Day 12/28/194	Year)	9. Birthp Cour	place (State or Foreign htry) Florida
	faryland ed at	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo	roe¹s		y, Town or Lo		on.					1	0d. Inside City Limits 1 ☐ Yes XXXX No
	with the Page or 28a-	i Director	10e. Street and Number 9203 Ivanhoe Road		1		10f. 2	Zip Code	0744		1	0g. Citizen o	What Cour	ntry?
136	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itame 23e or 28e-f ehow avent, the Madiral Examinar mala be notified at	by Funeral	11. Marital Status 1 Never Married 2000 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1XXYes 2 If Yes, Give Year or Dates:	Ever in U			edent of Hi ecify Cuba	ispanic Origin n, Mexican, F Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)	14. Ra	ace - Americ ack, White,	
Maryland 21215-0036	swithin 72 ho piene. r than "naturi the Madical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Deced (Give life. Comput	kind of t DO NOT	vork done d use retired	during most of)	f working	g	16b. Kind of State	Business/In	
yland	og ia b ₹	To Be C	17. Father's Name (First, Middle, Last) Alonzo Long			-			Earma I	Lee W			·	
, Mar	47.5		19a. Informant's Name/Relationship (Catherine White / Wi			9203	Ivanh	ioe Roa	d Ft. Wa		Route Number		n, State, Zip 20744	•
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			Place of Dispo emetery, crei ington N				Da 25/20		20c. Location Arlingt		
Balt	permit. Departrimporte any inju		21. Signature of Funeral Service Licer	1		22	2. Name	and Addres	ss of Facility G	eorge	e P. Kala Hill. M	s Funer	al Home 20745	PA
	Physician /Medical Examiner		23a. land. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a										Approximate Interval Between Onset and Death	
,097	te be executed ysicien and te burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HY Due to (or as c. Due to (or as	a conseq									
O. Box 68	The law requires that the death certificate the bas been signed by the ettending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic ⊒ Other (pregnancy specify)					ate of delive	ery Day Year
ds, P.	uires that signed by Id be deta		Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I.			pacco use co es 2 □ No		ne cause of death?
Hecords,		Completed									24a. Was a autops perform	ned?	. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of
Vital	s certificete director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatio	ent 2 XI	XER/Outpatier	nt 3□	Oth	ar-		Check only on	9	ther (Snecif	iv)
Division of	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director,		27. Manner of Death X⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	iry	28b. Time of Injury		28c. Injury Work	/ at	28	3d. Describe ho			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVIS	al or Attendi s after death. si Director: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of In building, et	ury - At ho c. (Specif	ome, farm, str	eet, fact	ory, office		28	Bf. Location (Si City or Town	reet and Nun n, State)	nber or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b	Medical ((Check only one)	yuician: To the best niner: On the basis o and manner st	f examina	wiedge dawl ition and/or in	h Joourne vestigati	ed at the two	ia, date and point on the control of	occurred	id due to the ci d at the time, d	ate and place	narmar as c , and due to	tated. the cause(s)
	To the within 2 To the complex	Ž	29b. Signature and title of cenifier	17.6	1	uu_	2	9c. License	2428	39	1	9d. Date sign April 13		Day, Year)
2	46		30. Name and address of person who David T. Isaacs, M.D.					101, S	uitland,	MD:	20748			
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 0 200	2. Registr	ar's Signa	aturė	D							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death **Physician** Month Year Mary Frances Warren April 15 2006 0713 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly
If Under 24 Hrs. Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗓 F Months Days Min. Yrs Director 220-16-7293 81 May 30, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. Stale 10d. Inside City Limits 28a-f ehow The Medical Examiner must be notified at 1 XYes 2 No Maryland Prince George's Upper Marlboro Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or 9511 Castle Drive 20772 deeth United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iter any injury or other traumatic event, the Medical Exertinat 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Day Care Provider Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Steven Watts Della Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. J. Warren/Husband 9511 Castle Drive, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 4/26/06 Maryland Veterans Cem. Cheltenham, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home wo 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown Division of Vital Records, P. ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 DUnknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient Certification: To 1 Inpatient 3□ DOA this After this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours a To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58957 person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State APR 2 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Werking Year **Physician** 12:30 DM Roger OL 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5712 Broadwater Creek Road Churchton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2 304-46-0145 64 Yrs. 1941 Indiana Director Aug. 16, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits •how in then "natural", or items 23a or 28a-f ehor 1 Yes XXNo Director MDAnne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5712 Broadwater Creek Road 20733 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes **XX**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mathematician Aerospace of Health and Mental Hygie fitem 27 ie marked other t r other traumatic event, other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Peed Mark C. Werking 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5712 Broadwater Creek Road, Churchton, MD 20733 Mary Margaret Werking (Wife) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department important: if eny injury or once. 4-14-2006 4 □ Donation 5 □ Other (Specify) Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funera Service Licensee 905 Galesville Road, Galesville, MD 20765 23a. Part1 Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart ailure. List only one cause on each line. Onset and Death Immedi e Cause Finaf di ease or co ditto r sultir g in de th Physician metastatic 12 months esophageal /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 ☐ Yes 2 X No certificate 1 Yes 2□ No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 No 1 Tes 2 ER/Outpatient 3 DOA 1 Inpatient this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier numer of death (Item 23a) (Type, Prin

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			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th	Vaar	3. Time of Death		
	Physici /Medic		Lucille E. W	hittinghan	m				April	15	2006	11:18 A.™		
7	Examin		4a. Facility Name (If not institution, give street and number			lb. City, Town, or I	Location of	f Death	-	1	ounty of Death	1		
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	Funeral			. Age (In yrs. last birth	N	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Feb. 2	Year)	9. Birth	place (State or Foreign		
	Director		210-20-1900	82 Y	rs.				Feb. 25	5, 19	24 Ma	rýland		
	pus A		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Locat	tion						10d. Inside City Limits		
	anyle	5	Maryland Baltimore			erstown						1 ☐ Yes 2√3 No		
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Maryland 21215-0036	be fi	Be	17. Father's Name (First, Middle, Last) William T. Heiland						(First, Middle, I		imame)			
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Ma	12 st h and 7 te n		19a. Informant's Name/Relationship (Type, Print) Diana Lynn Martin dau		_	Address (Street ar				-		-		
a,	1 and Health tem 27 other tr		20a, Method of Disposition	ghter 5		Church Ro	oad				D=211.			
JO.	Pages nent of int: If it iry or o		XXBurial 2 ☐ Cremation 3 ☐ Removal from St	cemetery	r, cremati	ory or other place. Cemeter	ν Δ	April			•	stown, MD		
Baltimore,	그런런 중 .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Funeral Service Licensee	1100										
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<u>о</u> .	uires that the death certific signed by the attending p d be detached for use as	Physician/Med	9 ☐ Unknown 9 ☐ Unknow	m										
	s the	by P	Part II. Other significant conditions contributing to dea	th but not resulting in	the unde	erlying cause giver	n in Part I.		23e. Did tol	bacco use	contribute to	the cause of death?		
Records,	w require been sig should b	pa	late perel	Think	~^\	5			1 □ Y	es 2 🖃 1	√6 3 □ Pro	bably 4 Unknown		
ည္ပ	law re as be 2 sho	Completed	Hy perten						24a. Was a		24b. Were aut	opsy findings available ompletion of cause of		
œ —	ician: The lav certificete has rector, page 2	E O	Recent Priema	سعت					perform	med? 2 ☑ No	death? 1 ☐ Yes			
ita	stan:	Be	25. Was case referred to medical examiner?				26. Place	of Death	(Check only on	6				
~	hysic his ce I dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Ing			3□ DOA Other	4 🗆 Nur	rsing Hor	ne 5 Reside	ence 6	Other (Spec	ıfy)		
בַ	ing P		27. Manne of Death 1 ☐ Natural 5 ☐ Pending (Month,	Injury 28b. Tir Day Year) Inj	jury	28c. Injury a Work?			28d. Describe ho	ow injury o	ccurred			
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Division of Vital	after of Direction by	Certification:	determined 286. Place 0	f Injury - At home, farr I, etc. <i>(Specify)</i>	m, street,	, factory, office		1	28f. Location (St City or Town		vum <i>ber</i> o <i>r Hu</i> i	ral Route Number,		
_	ospita hours uneral ly filled		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge,	death oc	ccurred at the time	e, date and	d place, a	and due to the ca	ause(s) ar	d manner as	stated.		
	24 H	ledicai	(Check only 2 Madical Examinar: On the bas one) and manne	is of examination and/ r stated.	Vor invest	tigation, in my opi	nion, deatl	h occurre						
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J	WH		Nay > W	V	thy		7		L	7/	111	06		
	10	-	30. Name and address/of person who completed cause	of death (Item 20%) (T	Type, Prin	n Ses	111	22	120	50	N Mr.	71117		
	Sta	te	31. Date filed (Month, Day, Year) 32, Reg	pistrar's Signature	161	-11	11/1/	18	1177) "	. 1 M. C.	<u> </u>		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Catherine I. Wise 0307 M topil 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ENIBULA egional medical NICOMICO salliba 8. Date of Birth (Month, Day, Year) Year If Und 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕌 F 80 Feb 6, Director MD 218-20-4529 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28s-f show the Madical Examiner must be notified at Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11536 Sinepuxent Road 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black δ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Housekeeper/Cook Various 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Emerson Purnell ပ Annie Fooks and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Depertment of Health ar Importent: If Isem 27 is eny injury or other trau once. Gabriel L. Purnell/son 9619 Mary Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ urial 2 □ Cremation 3 □ Removal from State St. Paul's Cemetery 4/22/2006 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home alasa Jellalson 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Artery /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine signed by the attending physicien and the detached for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si Om 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No After this certificate funeral director, pag 2□ No 1 ☐ Yes 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 1 Inpatient ို 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hospital or Attendin within 24 hours effer death.
To the Funeral Director: Af cympletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO05 3394 30. Nam. an 1/ ddress of person who completed cause of death (Item 23a) (Type, Print) 1205 Pemberton Pr, Salisbury MO Anthony Frey, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 1 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

ATTERIOR

			1 - For State Registrar	State of Marylan	d / Depa	artmer		alth and I	Mental Hyg	•	6	14190
	Physici /Medic		Decedent's Name (First, Middle, Last) Georgianna William	ns-Ayers					2. Date of Dea Month	Day	Year 004	3. Time of Death
)	Examir		4a. Facility Name (If not institution, give s	treet and number)	/	4b. City,		ocation of Death		4c. County	of Death	20
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 72	last birthday) Yrs.	If Under Months		If Under 4 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 1933	9. Birthp Cour	place (State or Foreign SC
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					1	Od. Inside City Limits
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030	ous after death with the Marylan ral', or Iteme 23a or 28a-f show Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 ☐ Yes		panic Origin? (Si Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: Bl	
9200-5121	"natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usu kind of wo DO NOT u	al Occupat ork done du ise retired)	on ring most of wor	king	16b. Kind of B	usiness/In	dustry
N	e filed within all Hygiene. other than vent, the M	Con	4th 17. Father's Name (First, Middle, Last)			L	abore		ne (First, Middle,		oultr	Υ
Maryland	a in p	To Be	Isom Scott, Sr.					Mary Pe			,	
Jar Z	2 should and Nen is marke aumatic		19a. Informant's Name/Relationship (Typ	· · · · · · · · · · · · · · · · · · ·		•	s (Street ar	d Number or Ru	ral Route Numbe		State, Zip	Code)
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Ē	Pages ment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	SHIOVALITOTTI STATE				rk 4/20,	/2006	Salisb	urv	ME
Baltimore,	permit. Depertm Importe any Inju		21. Signatur: Funeral Service License		22	2. Name ar Lewis	nd Address N. W	of Facility atson Fi	uneral Ho	ome		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not en	ter the mod	de of dying,	such as cardiac	lisbury, or respiratory are	est,	01	Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t	Pu	Im	lona	le.	ten	J, %		
68/60,	ficate be executed physicien and is the burial-transit	cal	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):							
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Vital	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:	50/0		Other		ath (Check only or	1	/0	
on of	Ing I	tlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury a Work?	4 □ Nursing ⊓	lome 5 ☐ Resid			y)
DIVISION	To the Heepitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific complete y filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st	reet, factor	y, office		28f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	al Route Number,
	To the Hospitel within 24 hours of To the Funerel completely filled	Medical (29a. Certifier 1	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, deat ition and/or in	h occurred ivestigation	at the time	, date and place nion, death occu	, and due to the derred at the time, o	ause(s) and m late and place,	anner as s and due to	tated. o the cause(s)
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	7 Jus			mpleted cause of death (Iter	n 23a) (Type,	Print)	100 = 1	conner.	st. Sal	hum	ma	2017
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 1 20	32. Segistrar's Signa	ature A	1.0						

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			1 - For State Registrar		State of N	larylar	-			ealth and Death		P	Reg. No	HIII		191
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	Funeral		5. Social Security Number 578-40-0671	6. Sex	M 2 F	ige (in yrs.	last birthday)	Months		Hours Min		Date of Birth (Month, Day				lace (State or Foreign try)
4	Director		Usual Residence of Decedent	1			73 Yrs.	<u> </u>	J		A	pril 2	4,1	932 Wa	ish:	ington, DC
	land ow		10a. State 10b. Coun	у		10c. Ci	ity, Town or Lo	cation							1	0d. Inside City Limits
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	r 288	Director	10e. Street and Number	IGLIC	-0		benear		ip Code				10g. Cit	tizen of Wha	t Coun	try?
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2	within ene. then	μ	Efementary/Secondary (0-12)		College (1-4o	r 5+)			use retired)						
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3	should be ind Mental marked o umatic eve	5	Wilmer Rudo	-								e Mart				
Na	12 short and reministration		19a. Informant's Name/Relation		•			-		and Number or R					te, Zip	Code)
	s 1 and 2 should Health and Meritem 27 le merke other traumatic		Dan M. White,	Sr./	Son	20h I	P.O. Place of Dispo	Box	203	Benedi	ct,	MD 20	612	Cin	T.	
0	~ ~ .		1 Burial 2 Cremation	3 □R	amoval from Stat	θ ,	cemetery, crei	natory`or	other plac	θ)	Dati			ocation - City		
Baltimore,	permit. Page Department of Important: If any njury or once.		4 Donation 5 Other			nt Tr						2006	Wal	dorf,	Mar	yland
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledical C	29a. Certifier 1 Certify (Crieck Only one)	ing Phys i Examin	ician: To the bes er: On the basis and manner	of examina	owledge, deatl	n occurre vestigatio	d at the tim n, in my op	ne, date and plac pinion, death occ	e, and urred	d due to the c at the time, d	ause(s) late and) and manne d place, and	r as sta due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certif	er				2	c. License	number		2	9d. Da	te signed (N	lonth, t	Day, Year)
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1	N	-	30. Name and a dress of perso	who cor	mpleted cause of	death (fter	m 23a) (Tyne	Print)	_				1 (- /		*
9	Sta	to.	ADEES JABES	-)	100 Ho	4.0	L RO.,		INCE	FREDER	ICK	MO	2	0678	3	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#28e-f, 10/06 III Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 1203 AM **Physician** PRIL 2006 DANIEL WISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Baltimore UNIVERSITY Of MARYLAND 8. Date of Birth (Month, Day, Year) 12/5/1951 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days IXIM 2□F 54 Yrs. NC 217-58-1610 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County ir than "natural", or items 23s or 28s-f ehow the Mcdical Examiner must be natified at 1X Yes 2 □ No Directo Ocean City Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21842 8 78th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 図 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Carpet Cleaning 5+ Owner/Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 le marked oth any injury or other traumatic evant <u>once</u>. Be Rose Rackley ဂ Daniel Crawford Wise, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 346 North Dr., Severna Park, MD 21146 Nanza W. Darley Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/28/2006 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service L The Burbage Funeral Home 108 William St., Berlin, MD 28111 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYSTEMIC Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit certificate be executed Narcotu that initiated events resulting in death) Last Due to (or as a consequence Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for o. 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1□ Yes 2∏ No certificate of Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Hospital: 1 Vinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death within 24 hours after death. To the Funeral Director: After 5 Pending investigation
6 D Could not be determined Attending Division 1 Natural 1 Yes 2 No UNKNOWN UNK 4-23-2006 2 Accident the 28f. Location (Street and Number of Rural Route Number, City or Town, State) 2219 Prentiss Flace 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō HOME Found residence Found residence TOTTE

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Certifying Physicien: To the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the Hospitel Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie A82500 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET. GREENE GILBERT MIDINIAN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2006

			1 - For State Registrar	State of Mary	rland / Dep	partment of ertificate of	Health and	Mental Hy		006	14193
Ph	ysicia	an	Decedent's Name (First, Middle, Last,					2. Date of De Month	ath Day	y Year	3. Time of Death
/1	/ledic	al	Andrew Zafis					April	14,	2006	5:50 P M
Ex	amin	er	4a. Facility Name (If not institution, give 1240 Derby Shire]				or Location of Dea	ath		County of Death	
Fun	eral		5. Social Security Number 6. Sec	7. Age (Ir	yrs. last birthday	Rockvil // If Under 1 Yea	r If Under 24 Hi		th	ont gomer	J
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laryland 21215-UU35 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23a or 28a-f show	an iner o	by Funerai	1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give		. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		(Specify Yes or No erto Rican, etc.))-	14. Race - Ameri Black, White, Specify:	
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be filed tal Hygi	Vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,		Sumame)	
arylal should b	atic	2	James John Zafis				Josephin	ne Przyby	10ws	ski	
2 € 5 ≤ 5	er traum		19a. Informant's Name/Relationship <i>(Ty.</i> MJ Zafis-Garcia/dau			ling Address <i>(Stree</i> Derby S					o Code)
Baltimore, bermit. Pages 1 at Depertment of Hea mportant: if item	ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	anioval noin state		position (Name of ematory or other place) ke Crema	1 *	ril 18,		cation - City or To	own, State Maryland
Baltimor permit. Pages Dependent of H Important: If ite	eny inju		21. Signature of Funeral Service License			22. Name and Add Soing Hom	ess of Facility				
₽hysic /Med Exami	ical		23a. Part1. Enter the disease, or complishock, or heart dilure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the	death. Do not er c Gastri	nter the mode of dy	 Heckroi ing, such as cardia 	ac or respiratory a	rrest,	rksvill	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. Due to (ur as a cu	ns u quanca of).						
ate be executed hysicien and	e burial-tran	cal Examiner	Catas (Disease of Injury that initiated events resulting in death) Last	Due to (or as a con	nsequence of):						
that the death certificate ed by the ettending phys	d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnand	су		2	23d. Date of deliver	ery Day Year
5 e g	tache	hys	9 □ Unknown	9□ Unknown							
0 8 G	28	۾	Part II. Other significant conditions con	tributing to death but no	t resulting in the	underlying cause g	ven in Part I.				ne cause of death?
e law	900	ompieted						24a. Was autop perfo	rmęd?	prior to co death?	psy findings available mpletion of cause of
VICAL FIGURE The Contificate	ior.	ည္တ	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath <i>Check only</i> o		1 🗆 Yes	2□ No
s de se	<u> </u>	2	examiner? 1 ☐ Yes 2 XNo	ospital: 1 🗌 Inpatient	2 ER/Outpatie	nt 3 DOA	hor	Home 5 ☐ Resid		S ther (Specif	Daughter's
Attending Physic description of the control of the	ie runera	ertification;	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time (Injury	We	iry at ork?]Yes 2 ∐No	28d. Describe h	now injury	y occurred	Tronte
To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the	ed in by I	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stoecify)	treet, factory, office		28f. Location (S City or Tox	Street and vn, State	d Number or Rura)	i Route Number,
he Hospi n 24 hou he Funer	Dietely III	edical	29a. Certifier (Check only one) 1 Cartifying Phys	ician: To the best of my er: On the basis of exa and manner stated.	knowledge, dea mination and/or ir	th occurred at the the threating the threating at threating at threat	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
To the vithing	E CO		29b. Signature and title of certifier			29c. Licen	se number		29d. Date	e signed (Month,	Day, Year)
/				~D		D356	35	A	pri1	17, 200	06
29 01			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type						
1	0.		Joseph Kaplan M.D. 31. Date filed (Month, Day, Year)	6001 Munca		11 Road 1	Rockville	e, Maryla	ind 2	20855	
Red	Stat gistra		APR 20 20	32. Registrar's S	ngilatur						

			For State Registrar		State of	Marylan		artmen rtificat					Reg. No.	. U U D	194
	Physici	an	1. Decedent's Name (F	irst, Middle, Last ZVIRBLIS)							2. Date of D Month	Day	Year	3. Time of Death
	/Medio	al	PETER 2 4a. Facility Name (If no		street and numb	ar)		4b City	Town or	Location	of Death	April	15 4c.	2006 County of De	
Ė.	Examir	er-	Shady Gro				L		ckvi					Montgo	
	Funeral Director		5. Social Security Number 297–12–302	ber 6. Se		Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, I May 7,	Dav Year)	(irthplace (State or Foreign Country) 110
	pue M		Usual Residence of De	cedent b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Manyli 4 eho	jo		Montgome	ry	S	ilver	Sprin	g						1⊈ Yes 2 □ No
	r 28a	Irec	10e. Street and Number	or			-	10f. Zip	Code				10g. Cit	izen of What (Country?
	23a o	al D	705 Canno	n Road					904					.s.A.	
36	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other then "nature!' or iteme 23a or 28a-i ehow enty Injury or other traumatic event, the Medical Expriner must be conflied at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐		12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date	ss? 【[] No		Was Decedif Yes, spe				ecify Yes or N Rican, etc.)	No-	Black, Wh	
21215-0036	ithin 72 hou ie. ien "nature Medical E	Completed	15 (Specify Elementary/Seconda	. Decedent's Edu only highest grad	le completed) College (1-4	or 5+)	1	dent's Usu kind of wo DO NOT u	rk done d se retired	during mos ()	st of work	ing	Dr	ind of Busines ugs pr dispen	eparation
121	lled w tygier her th		17. Father's Name (Fire	et Middle (ast)	4 Year	S	r	Harma	CISC		er's Name	e (First, Midd			J6
Maryland	uld be fi Mental H nrked of	To Be	George Zv	irblis						Pa	ulin	e Gai	junas	3	
Jan	2 sho		19a. Informant's Name									a <i>l R</i> oute Num Iarylan		r Town, State,	, Zip Code)
	1 end Health em 27		William M. 20a. Method of Dispos		, JI/ Kep	20b. P	lace of Dispo	osition (Na	ne of			Date			or Town, State
nor	Se in a se in		1 ⊠ Burial 2 □ C 4 □ Donation 5 [remation 3 DF		Tri	emetery, cre nity I	matory or o	can (Cem.	4/19	/2006	Jopp	a, Mar	yland
Baltimore,	permit. I Departm Importar eny Injur		21. Signature of Funer			\\ \tau	H.	2. Name a INES- 1800	nd Addres RINA New	ss of Facili LDI F Hamps	UNER Shire	AL HOM	E, IN Silve	NC. er Spri	ng, MD 20904
68760,	Physician was percented with principle and physician and p	Ical Examiner	23a. Part1. Enter the shock, or hearts when the shock, or hearts immediate Cause (Findisease or condition resulting in death) Sequentially list condition and the shock of th	tions, sidiate ng	Septic Due to (or b. Sepsis Due to (or c. Acute	shock as a consequence Syndr as a consequence Respir as a consequence as a consequence	uence of): come uence of): catory								Interval Between Onset and Death
.O. Box 6	thet the death certificate to the by the attending physis detached for use as the to the the the the the the the the the the	Physician/Med	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 □ Yes 2 □ N 9 □ Unknown	egnant enths?		n 2 ☐ Feta It at time of d	Ideath 3	⊒Ectopic p ⊒ Other (s						23d. Date of d Month	lelivery Day Year
<u>α</u>	8 50	þ	Part II. Other signification Polio	nt conditions co	ntributing to deat	th but not res	ulting in the u	underlying	cause give	en in Part	l.		d tobacco i		to the cause of death? Probably 4 □Unknown
Sord	> 0 0	eted										24a. Wt		7	autopsy findings available
Vital Records,	he fa e has age 2	Completed										ре	topsy rformed? : 2█ No	prior to	o completion of cause of
/ita	sician: T certificat rector, pa	Be (25. Was case referred examiner?	-	Una sitati				0,5		e of Deat	h (Check onl)	у опв)		
o	ding Phys h. After this funeral di	tlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of	Injury Day Year)	28b. Time of Injury		28c. Injun Wor	4 🗆 N		ome 5 Re 28d. Describ		6 □Other (S _I ry occurred	pecify)
Division	in Pite	Sertification:		6 Could not be determined	289. Place of	Injury - At ho , etc. (Specif	ome, farm, st	reet, factor	y, office				(Street ar Town, State		Rural Route Number,
	e Hospitel 24 hours s e Funeral i	edical C	29a. Certifier 1[(Check only 2[one)	Certifying Phy Medical Exam	sician: To the basiner: On the basiner	is of examina	wledge, dea tion and/or in	th occurred nvestigation	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the red at the tim	ne cause(s e, date and) and manner d place, and d	as stated. ue to the cause(s)
	To the I within 2.	Me	29b. Signature and titl	e of certifier	· Ha			29		e number				-	nth, Day, Year)
•	15		1/14	11 B	(11 4)				D-41	.162			Apri	1 15,	
	•		30. Name and address V. Ganti	of person who con $M \cdot D \cdot $	ompleted cause 19529 Do	of death (Item octors	Drive	, Print) , Ger	mant	own,	Mary	yland 2	20874		
6.	St Regist	ate rar	31. Date filed (Month,		32, 100	gistrar's Signa	iture	solle)	,						

Zvirblis, Peter

				State of Ma					-	ene		
			For State Registrar			Cei	tificate of	Death		g. No. UU6	4 95	
	Physici	an	1. Decedent's Name (First, Middle, Last) DEALTALITAL ALIDEDT						2. Date of Death Month	Day Year	3. Time of Death 11:55 A M	
	/Medio		BENJAMIN AMBERT 4a. Facility Name (If not institution, give st	reet and number)			4b. City, Town, o	r Location of Death	4 / 2	28/ 2006 4c. County of De		
	LXamii	ici	CALVERT HOSPITAL				PRINCE	FREDRICK		CALVERT		
	Funeral Director		002-20-0043	M 2 F	(In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, JUNE 7,	1921 PU	irthplace (State or Foreign Country) IERTO RICO	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	cation				10d. Inside City Limits	
	e Man ta-f sh	ctor	MARYLAND CALVERT		SOLO	MON,	MARYLAN	D			1 □Yes 2 No	
	h with th	al Director	10e. Street and Number 13325 DOWELL ROAD				10f. Zip Code 2068	8		og. Citizen of What C United		
	tems tems	Funeral		2. Was Decedent Ev Armed Forces?		13. \	Was Decedent of H	lîspanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 □ No If Yes, Give Year or Dates:			1 X Yes 2 □ No	Specify:		Specify: †	HISPANIC	
15-(n 72 h "natu solca	Completed	15. Decedent's Educ (Specify only highest grade	completed)	168	a. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	ing 1	6b. Kind of Busines	s/Industry	
212	d with giene. Ir than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		CHINE OP			FACTOR	У	
p	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)						e (First, Middle, M	,		
ryla	hould d Men marke maric	ပို	PEDRO AMBERT 19a. Informant's Name/Relationship (Typ	e Print)	19	h Mailir	an Address (Street		RDA CARR	City or Town, State	Zin Code)	
	nd 2 salth an 27 is i		WANDA DURAN / DAUG								RYLAND 20653	
Baltimore,	es 1 a of Hea fitam rotha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place o	of Dispo	sition (Name of natory or other place	ce)		20c. Location - City of		
ţ	permit, Pages Department of Important: If i any injury or once.		*4 □ Donation 5 □ Other (Specify)		ST. R					RONX, NEW		
Bai	permii Depar impor any ir		21. Signature of Funeral Service License	11/1/1/1	OFS	ρ	avid J.	Weber	Fineral	Yomes Baltimor	e, MD 2123	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to	ne death. Do	not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
	Prysician	1	Immediate Cause (Final disease or condition									
	/Medical Examiner		resulting in death)	Due to (or as a		of):					hanas	
		Jer	Sequentially list conditions, b.	Asp. Vat	nonsequence		ninia				700003	
	acuted .nd transit	Examiner	Sequentially list conditions, if any, leading to fine solitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	All Vance			~5~				yeurs	
,097	icate be executed physician and s the burial-transit	cal Ex	resulting in death, cast	Due to (or as a	,	- /-	en dis	(lmg-			years	
89	ificate g phys as the	ed	d.)	-					1	
Вох	The law requires that the death certificate tte has been signed by the attending physbage 2 should be detached for use as the	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. If yes, outcome of 1 Live birth 2	Fetal deat		Ectopic pregnancy Other (specify)	′		23d. Date of d Month	elivery Day Year	
P.O.	at the d by th etache	Phys	9 🗆 Unknown	9□ Unknown		1 - Ab	4.4.	on to Donal	22a Didtah	aaaa uu a aantrihuta	to the cause of death?	
	quires the signeral side be d	ed by	Part II. Other significant conditions cont			in the ur	ndenying cause giv	en in Part I.			Probably 4 Donknown	
eco	law requir as been s 2 should	Completed	Oizheter mellet	2 type					24a. Was ar		autopsy findings available c completion of cause of	
al R		Con	Aurtre Stenosis						perform			
VII:	Physician: r this certificaral director,	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{TNo} \)	ospital:	2 🗆 🗆 🗆	utnation	t 3 DOA Oth	0.00	h (Check only one	nce 6 □Other (Sp	annife)	
Division of Vital Records,	ding Phy h, After this funeral d	-	27. Mann of Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b.	Time of Injury	28c. Injur Wor	y at	28d. Describe ho		<i>веспу)</i>	
Divisi	l or Attending after death, Diractor: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	arm, str	eet, factory, office		28f. Location (Str City or Town,	eet and Number or i , State)	Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	xamination a	je, death nd/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)	
	within To the comple	Me	29b. Signature and title of certifier				29c. Licens		29	d. Date signed (Mo	nth, Day, Year)	
}	1		▶ U/ , mo				06	0390		04/28	/2006	
,	3		30. Name and address of person who con ADEEB JABER, 10	O HOSPITA	L RO.	P	Print) 21NCE F	REDERICK	, mo z	0678		
	Sta Registr	-	31. Date filed (Month, Day, Year) NAY 0 5 2006	32. Registrar	's Signature	Sign	all i					

			1 - For State Registrar	State of Man		artment of F		Mental Hy	- L U U U	14196
1		Ķ.	1. Decedent's Name (First, Middle, La			ranoate or	Death	2. Date of D		3. Time of Death
1	Physici /Media		CARL BL	EAKNEY	BECI	KERS		Apri	Day Year	36 4:08 AM
	Examir	er	44. Facility Name (If not institution, give 4412 Summe	e street and number) .Q GRAPE	ROAD		r Location of Dea	_	4c. County of De	ath LMORE
	Funeral Director	mund	5. Social Security Number 6. S 486-40-3652	ex 7. Age (li	n yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, rear)	irthplace (State or Foreign Country)
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ime 23e or 28e-1 show ir must be notified at	ţ	Maryland Baltir			esville				1 ☐ Yes 2 No
	or 28e	Olrec	10e. Street and Number	_		10f. Zip Code			10g. Citizen of What (Country?
	e 23e	ral		r Grape R		2120			USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Menial Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28e-1 show or other traumatic event, Its Madical Examinar must be notified at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 195		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	14. Race - An Black, Wh Specify: \	ite, etc.
215-0036	72 hou nature ilesi E		15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind of Busines	s/Industry
121	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)		1 —	. 4
d 21	filed withi Hygiene. other then	e Co	17. Father's Name (First, Middle, Last,	2	1	Investme			Financi e, Maiden Surname)	al
Maryland	Mental Mental arked c	To B	Carl Louis	Alexander	Becker	rs			Bleakne	ev .
lary	2 shol and h le ma		19a. Informant's Name/Relationship (**			_		ber, City or Town, State	
-	1 and Health Inm 27 ther tr		Liga S. Beckers 20a. Method of Disposition		4412 20b. Place of Dispo		Grape	Road	Pikesville 20c. Location - City of	MD 21208
nor	Pages nent of H int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🐯 Onation 5 ☐ Other (Specif	Domoural from State	cemetery, cre	matory or other place			Hanover.	
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tra ance.		21. Signature of Funeral Service Licer		21 PINOTONY (21-	2. Name and Addre	ss of Facility A	natomy 6	difts Regis	ry
ä	8 0 E 8		13 5							over, MD 21076
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dyin	ng, such as cardia	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a PROST	ATE	CARCI	NOMA			FOUR YEARS
	Examiner			Due to (or as a co	onsequence of):					
ja v	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):					
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):	-				
8760,	cate be executed physician and s the burial-transit	dical E		d						
9	rtificat ng phy as the	Nedlo	IF FEMALE:							
Вох	eath certifi attending I I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy	,		23d. Date of d	elivery Day Year
P.O.	the de y the a	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	e of death 5	Other (specify)				34,
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Pr	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Records,	w require been sig should b	ted t					·	10	Yes 2 No 3 ∏ F	Probably 4 Unknown
ec	elawr hasbe ge 2 sh	Completed						24a. Was	opsy prior to	autopsy findings available completion of cause of
alF		e Cor	25 Was asso referred to medical					1 ☐ Yes		s 2DNo
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatier	nt 3 DOA Oth		Home 5 Pas	one) sidence 6 □Other (Sp	acity)
Jo u	ng Phy ter thi neral o		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injun Work	v at		how injury occurred	өспу)
Slo	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No			·
Division	l or At after o Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office			(Street and Number or F own, State)	Ru <i>ral Route N</i> um <i>ber</i> ,
_	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, deatl	h occurred at the tin	ne, date and plac	e, and due to the	e cause(s) and manner a	as stated.
	the H hin 24 the Fi	Medical	5110)	niner: On the basis of exa	and/or in			urred at the time		
	To Will	<	29b. Signature and title of certifier	X		29c. Licens		11.6	29d. Date signed (Mor	ath, Day, Year)
			30 Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	05196	76	11/10	01 -00
	10*1		ROBERTO PIL	JOHNS +	PKINS	HOSPITA	L 1650	ORLEAN	US ST BALT	TIMO RE MOZIZZ
	Sta Registr		31. Date filed (Month, Day, Tear)	32. Registrar's	Signature	well				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** reddie Year 11.45PM Fist 194 2006 /Medical Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Rayenwood Baltimore Nursing NA If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 249-44-5485 Director 73 7-8-1932 S.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Baltimore 1 Yes 2 No Funeral Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 501 W. Franklin Street filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 Yes 2X No Specify: 3 Widowed 4 Divorced Black "netural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 74 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne any injury or other traumatic event, Ite Mades one. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Varies Unkn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belin Belin Rene Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 918 Seagull Avenue, Baltijmore, Md. Sharon Stocks Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 5-8-06 Dundalk, Md. 21. Signature Tuneral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardio Vascular /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☑ No 2 No 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death | Check only one Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification; 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours after To the Funeral Direct 4 Homicide 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Amount W Macem death (Item 23a) (Type, Print) TUNN MACEM 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 7:07 PM Mou 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Center BRITIMORE tf Under 1 Year | If Under 24 Hrs. Sociat Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Grantry) 219-52-977 1 □ M 2 🗷 F Months Days Hours Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: P 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) W. 21 34 a1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metabolic acidosis Due to (or as a consequence of): Sepsis Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

Physician /Medical Examiner

for use as the burial-transit

ò Department of Important: If any injury or once.

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other then "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or Itsms 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at

Completed by Funeral Director

Be ျှ

/Medical

Examiner After this certificate has been signe funeral director, page 2 should be within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by and intraparenchymal 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year)

dress of person who completed cause of death (Item 23a) (Type, Print)

South 2006 32. Registrar's Signature

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and a

31. Date filed (Month, Day, Year) MAY 0

Balhmore MD

				1- For Amend Item 23d per Dr., G855, 05/05/06dip Certificate of Death	Mental Hygi	ene	6 14199
		Dhuniai		Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
		Physici /Medio		William Timothy Boswell	05		5:00 AM
		Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County	
				Genesis MultiMedical Center Towson			ltimore
		Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year 4 Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
		Director		Usual Residence of Decedent	08/11/1	952	FID
		rland Iow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		Man	tor	MD Baltimore Towson			1 ☐ Yes 2. No
		h the	irec	10e. Street and Number 10f. Zip Code	10	g. Citizen of W	hat Country?
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		itema itema	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian,
	36	s afte	Y FL	1 X Never Married 2 Married 1 X Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify:	Black
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9		s 1 and 2 should if Health and Mer item 27 ie marke other traumatic		, , , , , , , , , , , , , , , , , , , ,			MD 21286
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				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between
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~	0.	t the de by the tached	hys	9 ☐ Unknown			
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ורני		To the Hospital within 24 hours and the Funeral I completely filled	Medical Certification:	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the car	use(s) and man	ner as stated.
3		the H in 24 the F nplete	ledi	one) and manner stated.			
		To the within To the comple	2	29b. Signature and title of certifier 29c. License number	I I I	d. Date signed	(Month, Day, Year)
	/	Ω		SpepterD DOOS315		11110	1 5× 2006
	(0	4)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakunnaha Gupta 9650 Santiaco K	COAD	5017	E110 ND NB/A 21045
		Sta	te.	21 Date filed (Month Day York) 22 Registrade Signature		4000	N15175 2109)
		Registr		31. Date lines (month), Day, Teal)			

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			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ıth	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
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г	Funeral Director		5. Social Security Number 6. Sec. 15	(7. Age ((In yrs. last birthday) 74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Birth	place (State or Foreign ntry)
			Usual Residence of Decedent		/4			11/12/	1931 MARY	LAND
	nylanch how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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ဓ္ဓ	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
P.O. Box	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death 5L	Other (specify)				,
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Division of Vital Records,	ding Physician: The lav. h. After this certificate has funeral director, page 2	ü.	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day		Work		28d. Describe h	ow injury occurred	
Sic	death death stor: / the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	39a Place of Inju	une. At home form etc		Yes 2□No	20f Location (C	tmot and Alumbas as Due	ol Courte Number
<u>≥</u>	or A efter Direction by	Certification:	4 Homicide determined	building, etc	iry - At home, farm, str :. <i>(Specify)</i>	еві, гаскогу, опісе		City or Tow	treet and Number or Rura n, State)	ar Houle Number,
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	he Ho in 24 he Fu pletel	edical	(Check unity 2 Medical Examil one)	and manner sta	examination and/or in- ted.	vestigation, in my or	oinion, death occur	red at the time, o	late and place, and due to	o the cause(s)
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	141		30. Name and address of person who co	mpleted cause of de	eath (Item)23a) (Type,		. Wastr	ninstes	E (MD 2	1157
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	Registra		MAY 0 5 2006	See >	M. Aires	160				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	-	artment of rtificate of			giene 006	14201
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Andrew P	Barn		or Location of Dea	2. Date of Dea	Day Year 2 & 20	06 529PM
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Maryland	s 1 end 2 should be filed within f Heelth and Mental Hygiene. Item 27 is marked other then other traumatic avant, the Ma	To Be C	17. Father's Name (First, Middle, Last) Andy Barmes 19a. Informant's Name/Relationship (1)		19b. Mailir	ng Address (Stree	Angie 1	ame (First, Middle, Donaldson Bural Route Numbe		a, Zip Code)
-	0 0		Andy Barmes/father 20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	3203 Place of Dispo	Old Bruce of the poly of other pi	ceville R	d. Vino	cennes, IN	v 47951 or Town, State
Baltimore,	permit. Peg Department Important: I any injury o		21. Signature of Funeral Service Licen			Name and Add	tery May ress of Facility nell-Wiede York Rd.	efeld Fun	eral Home	s, Indiana Inc. 21212
	Physician /Medical Examiner	Examiner	23a Part. Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conscibility) Due to (or as a conscibility) Due to (or as a conscibility)	equence of):	pirato	Failur	tress s	yndrome	Approximate Interval Between Onset and Death 13 days
>'09289	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit		resulting in death) Last	d. Due to (or as a conse	equence of):	uko a	dystr	phy		21 years
P.O. Box	the death certific y the attending pl sched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnan Other (specify)	су	<u>'</u>	23d. Date of o Month	delivery Day Year
Records, P	w requires thet the de been signed by the s should be detached f	þ	Part II. Other significant conditions o	ontributing to death but not re	esulting in the u	nderlying cause g	given in Part I.	23e. Did to		e to the cause of death? Probably 4 □Unknown
Vital Rec	ilcian: The law certificete hes b rector, page 2 s	Be Completed	25. Was case referred to medical				26. Place of De	24a. Was a autop perfor 1 Yes	rmed? death 2 No 1 □ Y	
of	at te	၉	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	ther: 4 🗆 Nursing	Home 5 ☐ Resid	ence 6 Other (S	pecify)
Division	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	i Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	city)	eet, factory, office	9	City or Tow	n, State)	Rural Route Number,
	tha Hosp in 24 hol tha Fune	Medicai	(Check only 2 Medical Examone)	ysician: To the best of my kinner: On the basis of examinated and manner stated.	nowledge, death nation and/or inv	vestigation, in my	opinion, death occ	curred at the time, o	date and place, and d	lue to the cause(s)
	To with	2	29b. Signature and title of certifier	~ ne	2		RES -		APRIL (Ma	
	4		30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)	0 N. i	NOLFE	St. Ba	18, 2006 LTIMORE MD
Ì	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	F. 10.	,		1	21287

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		State of	Maryla			nt of Ho te of D	ealth and I Death		giene ()	06	1202
	Physic		1. Decedent's Name (Fir. Dennis	www.	cline	9					2. Date of De Month	ath Day	Year 2006	3. Time of Death
	/Medi Examir		4a. Facility Name (If not	nstitution, give	street and num	ber)		4b. City	, Town, or	Location of Death		4c. Cour	nty of Death	0.001
			BAltimore W	ashinat	on Med	ical C	enter	Gle	n Bo	urnie		Ann	e ARU	NDEL
Ĭ	Funeral		5. Social Security Number	r 6. Se			. last birthday)		r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		214-54-9842		AM 2UF		56 Yrs.				May 20 1949 MD			MD
	land		Usual Residence of Dece 10a. State 10b	County		10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
	the Maryland r 28a-f show	tō	Maryland A	nne Ar	undel				Glen	Burnie				1 ☐ Yes 2 ☒ No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number					10f. Zi	p Code			10g. Citizen o	of What Cour	ntry?
	23a c	ie D	109 Beth R	oad						21060			USA	
		nei	11. Marital Status		12. Was Deced Armed Ford	es?	J.S. 13.	Was Dece If Yes, spe	dent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. R	ace - Amend lack, White,	
15	within 72 hours after ene. than "natural", or ite fre Middical Examine	by Fi	1 Never Married :	,,	1 ⊠Yes 2 If Yes, Give Year or Dal	! □ No			2 No				ity: Whi	
Den n i 1215-003	72 hours "natural"	ed		ecedent's Edi		-	16a. Dece	dent's Usu	al Occupa	tion		16b. Kind of	Business/Inc	dustov
215	hin 7:	pie	(Specify on Elementary/Secondary	ly highest grad	College (1-	1or 5+)	(Give	kind of wo DO NOT L	ork done du ise retired)	uring most of wor	king			,
2 5	if Hygiene. A Hygiene. Other than	Completed	12				La	b Tec	chniç	ian		Northr	up Gri	umman
	be file d oth	To Be	17. Father's Name (First,							18. Mother's Nan			ame)	
	ould 1 Men nark	ပ		Garfiel		ne	7			Mary	Zei			
CLINE Dennis Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Ira Monce.		19a. Informant's Name/F		_{урв, Рппі)} (spous	e)				<i>nd Number or Ru</i> , Glen B				Code)
و ل	Heal Heal tem 2		20a. Method of Disposition		(Spous	20h	Place of Disno	estion /Na	me of		Date	20c. Location		wn, State
QE C	Pages ent of nt: if i		1 □ X Burial 2 □ Cre 4 □ Donation 5 □			ale	cometery, crei			" May	006	Elkridg	ıe Man	cvland
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<u> </u>	88558	\$ JI	Much		Dal	Lixe	11	3111	Moun'	tain Rd.	, Pasade	ena, Mo	a 21 72	ije, P.A.
			23a. Part I. Enter the dis shock, or heart failu	ease, or comp. ire. List only o	lications that can one cause on ear	used the dea ch line.	th). Do not ent	ter the mo	de of dying	, such as cardiac	or respiratory ai	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	1	a	1006	F571	15	HED	412T F	=17:Lu.2	É		Onset and Death
	/Medical Examiner		resulting in death)							_	WEARC			
	\$	-	Sequentially list condition if any, leading to immedi	ns,		A CUT	quence of):	1400	1201	H In	WEARC	1) On		
V	uted d ansit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	~										
·	exec an an rial-tr	Еха	resulting in death) Last	- 1	Due to (o	r as a conse	quence of):							
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9	eath certifica attending ph	Physician/Medical	IF FEMALE:											
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	that the de led by the a detached (ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnad 9□Unknov	nt at time of o	death 5∟	Other (s)	oecity)					
0	requires that the death certific een signed by the attending p hould be detached for use as	y Ph	Part II. Other significant	conditions co	ntributing to dea	th but not res	sulting in the u	nderlying o	ause giver	n in Part I.	23e. Did to	obacco use co	ntribute to th	e cause of death?
rds	w requires that been signed to should be detailed.	ed by									101	′es 2□No	3 Prob	ably 4 dunknown
ပ္တ	law renas bee	Completed									24a. Was		. Were autor	osy findings available
ä	The law ate has page 2	E									autop perfo 1 Tes	rmed?	death?	npletion of cause of
ita	ician: Th certificate rector, pag	Be	25. Was case referred to examiner?	medical		/				26. Place of Dea	77.7	-		223110
>	Physician: this certificaral director,	၉	1 ☐ Yes 2 ☑ No	ŀ	Hospital: 1 🗆 np] ER/Outpatier			4 Nursing n	ome 5□Resid	ience 6 □O	ther (Specify)
- L	ling P	io iii		Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injury a Work?		28d. Describe h	low injury occu	urred	
Division of Vital Becords.	death ctor: / the	licat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	28e Place o	f Injury - At h	ome, farm, str	M factor		es 2□No	28f Location /9	Street and Nun	abor or Rum	Route Number.
<u>~</u>	after after Direct	Certification;	4 Homicide	determined	building	, etc. (Speci	fy)	eet, ractor	y, onice		City or Tou	m, State)	ibei oi riura.	House Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 12	ertifying Phy	sician: To the b	est of my kn	owledge, death	n occurred	at the time	, date and place,	and due to the	cause(s) and n	nanner as st	ated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2	ledical Exami	ner: On the bas and manne	is of examina	ation and/or in	vestigation	i, in my opi	nion, death occur	red at the time,	date and place	, and due to	the cause(s)
	with To t	Σ	29b. Signature and title o	certifier	0				c. License			29d. Date sign	•	
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100	Sta	to	BALTMON 31. Date filed (Month, Da	W Wi7s	30 Rec	istrar's Sign	-DICHE	CC	かんな	- 6-Lit	134121	NIC 6	LU .	20900
- 1	Registr		MAY	0 5 200	5 Fear	ne a	S. Aco	12.5						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar Certificate of Death Red. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Dast) **Physician** 8:45 A.M aumond 2006 /Medical 4a. Facility Name (It not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner hosapeake Med. 5. Social Security Number 212 - 48 - 79 Air HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 1 M 2 □ F -7980 Yrs Director 212 - 413 - 79 80 Usual Residence of Decedent DALTIMORE, MC 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "naturel", or itame 23a or 28a-1 show or other treumatic event, the Modical Examples investigate and of the modified at MD 1 Yes 2 No Director HARFORD ngdon 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21009 Merrick Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mochanic Lngold's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental h Mary acriek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) important: If item 27 is.
any injury or other treur. 10514 Maronda 50n KIVETVIEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Dave 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evanstuneial Chapal-Odlin Forest Hi 21. Signature of Funeral Service Licens e Forest Hill MD Erans Funeral Chasel-BelAir 3Wewforts 23a. Part 1: Enter the disease, or complications that caused the di ath Do not enter the mode of dying, such as cardiac or r spiratory arrest, shock, or heart failure. List only one cause on each line. Ap oximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lacionse Physician one worth /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Quito (or as a consequence of): signed by the attending physicien I be detached for use as the buria Physician/Medical 23d. Qalers REDICK SYAMIN Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Year CERTIFICATION 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate has autopsy 1 Yes 2 No Vital 1 ☐ Yes 2 100 25. Was case referred to medical funeral director 26. Place of Death | Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 201 2 ER/Outpatient 1 (hpatient 3 DOA of After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Haturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai Cartifying Physician: To the best of my knowledge death occurred at the time, date and plane, and dise to the causes(s) and mainter as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check brit) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m.D. D45390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MyD Min (M-D.) GOZ South Atwood Road #200 Bel Air

State
Registrar

31. Date filed (Month, Day, Year) MAY 0 5

M80039832

32 Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 2, May 2006 Curtis Arthur Cash /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7848 Gough Street Colgate If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□F 239-16-3322 86 Director 02/07/1920 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1740 Bayard Avenue 21222 United States Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1942–45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Molder & Surveyor Steel Manufacturer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Ie marked oth-eny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J.B. Cash Minnie Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Carrie J. Maynor - Daughter 1740 Bayard Avenue Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 05/06/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee David J. Weber Fineral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Candiovascular D terio Sc **Physician** 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 physician Physician/Medical the use as attending 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 ☐ Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 X Yes 2 □ No funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother Supplier's 2 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. the Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide after within 24 hours a
To the Funeral E
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifiet Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

34

State Registrar 31. Date filed (Month,

141

pleted cause of death (Item, 23a) (Type, Print)

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:20 AM **Physician** CLAVTON BRADLEY 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** EARle ISland ec12 KNIGht If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

WHAY PUD 7. Age (fn yrs. fast birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours M 2□ F 218-28-6413 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "naturel", or Itams 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at Cecil 1 ☐ Yes 2 No RATIEVILLE Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21919 U-S.A. S/ANB Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No NAUY 11 Marital Status be filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: Korcan 1 ☐ Yes 2 No Specify: Specify: hite ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Supreme Aluminum College (1-4or 5+) Elementary/Secondary (0-12) oduction 2 (First, Middle, Maiden Sumame) 18. Mother's Name 17. Father's Name (First, Middle, Last) Be n and Mental H BRADLCY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ArdeAN KNIGHT f Health i EARLEVILLE Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
important: If Ite
any Injury or ott Burial 2 ☐ Cremation 3 Removal from State BAITO. MAKY IAND DAKLAWN CENETERY MAY 8, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNCRAL Home 263 5. CONFEING Street BAITO MD=1224 23a. Part. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin II disease or condition resulting in death) 14 menths **Physician** he mato cancinom /Medical Due to (or as a consequence of): Examiner 28665 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed the burial-transit 040 64 et. that initiated events resulting in death) Last attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the o 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 No e Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 22 No 24a. Was an autopsy performed? page 2 certificate has 1 Yes 2 No Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5.12 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After I Division Injury 5 Pending investigation or Attending 1 Natural death. 2 Accident completely filled in by the Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 THomicide after within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00035779 May

Registrar

State

2515, Bohomia Aver,

Cecilton, and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hain

32 Registrar's Signature

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MAY 0 5 2006

31. Date filed (Month, Day, Year)

									Mental Hyg	iene	to an or
			1 - For State Registrar	Olato or int	ar y tarra		rtificate of			2006	14206
-			Decedent's Name (First, Middle, Last	st)		·			2. Date of Deat	h	3. Time of Death
	Physici /Medic		Margaret V. Cr	awford					Month May 4	Day Year	3:35 A. ^M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of De	ath	4c. County of Deatl	
Ķ.			Rose Manor					ott City		Howar	
г	Funeral Director		5. Social Security Number 6. S 215–34–8516	ex ☐ M 2 Q F	9 (In yrs. Ias 93	it birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year) 9. Birth Co.	nplace (State or Foreign untry) yland
			Usual Residence of Decedent						APLIL 3	, I JI J Hal	y Land
	nylan thow	L	10a. State 10b. County		10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Be-f s	Director	Maryland Howard		Syl	kesvi	1				1 ☐ Yes 2 🛣 No
	with th		10e. Street and Number				10f. Zip Code		10	ng. Citizen of What Co	untry?
	eath	erai	579 Gaither Road 11. Marital Status	12. Was Decedent	Ever in U.S.	13 1	21784	Hispanic Origin?	(Specify Ves or No-	USA 14. Race - Ame	ican Indian
0	r Iter o	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆					(Specify Yes or No- erto Rican, etc.)	Black, White	, etc.
ğ	ours a	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2⊠No	Specify:		Specify: Wh	ıte
5	"natu	iete	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	oation during most of v	vorking	16b. Kind of Business/	ndustry
12	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		es Assoc:			Retail	
2	illed Hygi othar	Be Co	17. Father's Name (First, Middle, Last)						lame (First, Middle, M		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked othar than "natural", or Items 23s or 28e-f show imetic event, the Model Exametric from the Lorentified at	To B	Charles W. Aller	valt				M. Jul	ia Carney		
ar)	2 shi and is m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Number,	City or Town, State, Z	ip Code)
	s 1 and 3 Health item 27 other tra		Gail Rowe Daugh	nter	noh Die			Road; Sy		Maryland 2	
סב	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cen	netery, cren	sition (Name of matory or other pla	· 1		20c. Location - City or 1	
Baltimore,	permit. Pages Department of I Important: If it any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		Lorra		Park Cem			oodlawn, Ma	
Ba	Deporting any any once		1 / MAD	Hall		F	uneral H	ome of C	Catonsville	hton Schwal e,Inc onsville, M	m 21228
A			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not ent	er the mode of dyi	ng, such as card	iac or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition				diseas				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as							
	Laminer	<u></u>	Sequentially list conditions,	b. Due to (or as	a conseque	nce of):					
7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							r	
ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):					
3760,	ys Je	Ical	(d							
9 ×	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE:	OZa Kwas automa	of						
Box	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli- Month	very Day Year
o.	the de	ysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	time or dear		Other (specify)				
ď.	res that the de signed by the a be detached f	by PI	Part II. Other significant conditions of	-		-			23e. Did tob	acco use contribute to	the cause of death?
Srd	w require been sig should b	ted t	Dehy dration	Coro	nory	arts	y disea	ye_	1 □ Ye	s 2 No 3 □ Pro	babty 4 Unknown
Records,	law r las be	Completed							24a. Was ar autopsy	prior to o	opsy findings available ompletion of cause of
۳ ج		Con							perform 1 ☐ Yes 2		2000
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			O#	-	eath (Check only one		P 4-12 2
ō	iding Physicien: th. : After this certifica) funeral director, p	T. To	1 ☐ Yes 2 ☑No 27. Manner of Death	28a. Date of Injur	y 28	∛Outpatien Bb. Time of	28c. Inju	4 Minursing	Home 5 Resider	nce 6 Other (Spec	ify)
ion	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	Wo	rk? Yes 2□No			
Division	al or Attandi after death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home	e, farm, str	eet, factory, office		28f. Location (Str City or Town,	eet and Number or Rui State)	al Route Number,
<u> </u>	itel or rrs aft ral Di										
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best on niner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tile restigation, in my o	me, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To tha l within 2 To tha complet	Med	29b. Sign the and title of criffier	and marrier sta	Aller	tung	29c. Licens	se number		d. Date signed (Month	
ì	->-0		Value Cersan	2	Phy	Sicia	58 "	30631		5/4/06	
	a		30. Name and address of person who		eath (Item 2	3a) (Type,			01 (.	5/4/06 onsville, 1	85515 (
				singer I	II N	40.	700 (super	ed, lat	onsville,	1) 4268
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5	2006 32. Record	ars Signatur	е	Frank)		-		
	3.00				Mile Arriva		7				

	Physic	ian.	1 - State of Maryland / Department	ent of Health and M ate of Death	2. Date of Deat	g. No. UU	6 14207
	/Medi Examir	cal	011 1 1	City, Town, or Location of Death	April	4c. County	of Death timore
	Funeral Director		220-14-7941 1 M 2 F 91 Yrs. Monti	nder 1 Year If Under 24 Hrs. hts Days Hours Min.	8. Date of Birth (Month, Day, Dec • 29	1914	9. Birthplace (State or Foreign Country) West Virginia
	1215-0036 within 72 hours after death with the Maryland ane. ane. than "naturel; or items 23e or 28e-f show the Medical Exercipe transities at	rector	Maryland Baltimore 10e. City, Town or Location Parkville 10e. Street and Number 10f.	Zip Code	10	Citizen of V	10d. Inside City Limits 1 ☐ Yes 2▼ No What Country?
	r death with	ineral Di	8848 Green Needle Drive 21	1236 acedent of Hispanic Origin? (Specspecify Cuban, Mexican, Puerto F		U.S.A.	e - American Indian, k, White, etc.
	-0036 2 hours afte aturel; or it	ed by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a Decedent's Line Procedure 15. Decedent 15. Deced	s 2 XNo Specify:	1	Specify	White
	ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours att f Health and Mental Hygiene titem 27 is marked other than "naturel; or other traumatic event, tra Medical Exert.)	To Be Completed by Funeral Director	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) Waitres	work done during most of workin T use retired)	F	Restaur	ant
	Maryland 212: 12 should be filed within and Mental Hygiene. 18 marked other than raumatic event, tra M	To Be	17. Father's Name (First, Middle, Last) Marshall Irwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	18. Mother's Name Mary E. ress (Street and Number or Rural	Payne		
	ore, Me es 1 and 2: of Health ar fitem 27 1s			en Needle Drive	, Baltin	nore, M	
;	Baltimore, Misper I and 2 Department of Heath a Important: If item 27 is any injury or other tra		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name	aith Apr. 29 and Address of FacilitMille Belair Road, Ba	er-Dippe	1 Fune	
	p8 / bu, iificate be executed //Medicate be executed g physician and as the burial-transit	dicai Examiner	23a. Part. Inter the disease, or complications and caused the death. Do not enter the mishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	iode of dying, such as cardiac or Heart f	Ar Lu		Approximate Interval Between Ons at and Death
124,	death cert se attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other	c pregnancy (specify)		23d. Date Mon	e of delivery tth Day Year
2	KCOTGS, F w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did toba	1 -	ibute to the cause of death? 3 Probably 4 Unknown
26	VITAL MECOLOS sicien: The law requires certificate has been sign rector, page 2 should be	e Compieted	25. Was case referred to medical		-	ęd? d	Vere autopsy findings available rior to completion of cause of eath?
#	F yd sign	Certification; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 3 St. Time of Injury M				or (Specify) Hospice
Th	in the second		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurrence.		City or Town,	State)	or Or Rural Route Number,
A	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only one) I Medical Examiner: On the basis of examination and/or investigated and manner stated. 29b. Signature and till of pertifier	ed at the time, date and place, an ion, in my opinion, death occurred 29c License number W. Charles S	d at the time, date	e and place, a	nd due to the cause(s) (Month, Day, Year)
	Sta Registr	100	31. Date filed (Month, Day, Year) MAY 0 5 2006 32. Registrar's Signature	M. Charles J	n &	olts.	and = (20)x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year FULTON Month May 155 DM ONN Larry 2006 4a. Fecility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Kaltimore Hospital Mosedale Square Franklyn If Under 1 Year | If Under 24 Hrs. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 220-38-953 Md 6 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Middle altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21220 rcle Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) + H Auto Sales Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

45 Ambo

Garrison Forest Cam

3 Ectopic pregnancy

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Sollare

1 ☐ Yes 2 ☐ No

036663

5 ☐ Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

3a. Part. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or leart failure. List only on cause on each line.

Due to (r as consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

willed

9 Unknown

Hospital:

4□Pregnant at time of death

a

Circle

240 KEISTUSTE WA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

22. Name and Adress of Facility CHATH THE - / Jam's

Middle River

06

rown

20c. Location - City or Town, State

bothers Red 21611.

23d. Date of delivery

Day

3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

2 No

28d. Describe how injury occurred

24a. Was an autopsy performe 1□ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

YEMEN / YEM

Approximate Interval Between Onset and Death

DWINGS Mi

permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiens. Important: If tem 27 is marked other than "na any injury or other traumatic aver". Physician /Medical

1 - For State Registra

10a. State

45

VohN

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

2 No

IF FEMALE:

Kober

Jarcellina

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Servige Licensee

19a. Informant's Name/Relationship (Type, Print) Daugnter

1 Burial 2 Cremation 3 Removal from State

Herri

Director

ģ

Completed

Be

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or itams 23s or 28s-f show the Modical Examinar must be notified at

Maryland 21215-0036

Examiner

Examiner

Physician/Medical

Completed by

Medicai Certification: To Be

The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit this certificate has been signed al director, page 2 should be de

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

P.O.

Division of Vital Records,

State Registrar DHMH 17 Rev 1/2001

m

5 Pending investigation

6 Could not be determined

Registrar's Signature

eath (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA

28b. Time of

Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year FIELDS APHL 2006 12:31 DENISE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA THE JOHNS HOPKINS HOSPITAL CITY BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 45 Yrs. Director 142-58-5288 4-3-60 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "neturel", or Itams 23a or 28a-f ehov the Medical Examiner must be outified at 1 X Yes 2 ☐ No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 1334 N. Chester Street death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No ff Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home llth grade Homemake other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 9008. Be Fields Lyn Brenda Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodrow Ladson Financee 1334 N. Chester Street, Baltimore, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-5-06 Randallstown, Md. King Mem Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Warre Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACIDOSIS 24 HOURS /Medical Due to (or as a consequence of): Examiner PENAL FAILURE YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): The law requires that the death certificate be executed signed by the ettending physician and I be detached for use as the burial-transit 8 YEARS ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 ☐ Unknown σ. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 2× No 3 Probably 4 Unknown 1 Yes this certificate has been s al director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2/2/No 1 Yes of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 200 Hospital: ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wonyen MEDICAL DOCTOR RES-000 APPIL 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND UEN NOTUYEN, THE JOHNS HOPKINS HOSPITAL, GOT NORTH WOLFE STREET, BALTIMORE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2006 Registrar

DHMH 17 Rev 1/2001

06-02910

Please Type or Print in Black Indelible Ink

laudette Freem		S 1- For State Registrar	tate of Maryla		artment of rtificate of		Mental H		eg. No. 201	06 1421
Physicia Medical Examir	er	1. Decedent's Name (First, Midd Claudette		Free				2. Date of Dea Month April 30, 2	Day Year 2006	3. Time of Death 1001 hrs
		4a. Facility Name (if not institution Sacred Heart Hospital	. •	mber)		4b. City, Town, or I Cumberland			4c. County of Allegany	Death
Funeral Director		5. Social Security Number 342–42–1609		7. Age (In yrs. I	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs		th (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
w any	Ī	Usual Residence of Decedent 10a. State 10b. County		1	, Town or Locat			<u> </u>		10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	ector	TL COO	ok	Br	oadview	10f. Zip Code		1	0g Citizen of Wha	
th the M 23a or 2 notified		2420 Roosevelt				60153			USA	
er death , or ite	y Funeral Director		12. Was Dece Armed Fo 1 Yes vorced If Yes, Give Year	2 X No	If Y	is Decedent of Hisp es, specify Cuban, Yes $2[X]$ No	Mexican, Puerto		14. Race - White,	
6 n 72 hours afte an "natural" ical Examine	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1-		16a. Deceden during m	t's Usual Occupations of working life.	on (Give kind of v		16b. Kind of Busin	ness/Industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Be Comp	12 17. Father's Name (First, Middle Unknown	, Last)		Super	rvisor	8.Mother's Name	, , , , , , , , , , , , , , , , , , , ,	Maiden Surname)	1 & Gossett
7. P & g & l	라	19a. Informant's Name/Relation					and Number or F	Rural Route Nun	nber, City or Town,	State, Zip Code)
TOFE, MD 2 ages I and 2 shou nt of Health and N it: If item 27 is n other traumatic		DeVaughn Free 20a. Method of Disposition 1 X Burial 2 Crematio		1		Rooseve1 ition (Name of cem ner place)		Broadvi		60153 ity or Town, State
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	J,	4 Donation 5 Other S 21. Sign ture of Funeral Service	pecify:			Cemetery lame and Address		-2006	LaGrange	e, IL ineral Home
	1	an vo	Dodd !		53	45 W. Ma	dison St	reet, C	hicago,	LL 60644
Physician /Medical Examiner	1	 Part I. Enter the disease, o faiure. List only one cause Immediate Cause (Final disease or condition resulting in death) 	on each line.	e Atheroscl	lerotic Cardi			r respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a c. Due to (or as a							
xecute En 1 and - transit	sal Ex	events resulting in death) Last	d	oonsoquenee e				· <u>·</u>		
60, ate be exc hysician e burial -	Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, c	outcome of preg	inancy			_	23d. Date of de	elivery
Box 68760, e death certificate be the attending physicied for use as the buring	Physician/N	23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 ✔ Ur	ne 1 Live bi	rth ant at time of de	2 Fe	tal death 3 her (Specify)	Ectopic pregna	incy	Month	Day Year
ires that the d signed by the	<u>آھ</u>	Part II. Other significant condi	tions contributing to	death but not r	esulting in the u	inderlying cause gi	iven in Part I.			ite to the cause of death? Probably 4 Unknown
Division of Vital Records, P tal or Attending Physician: The law requires is after death. In Director: After this certificate has been sign led in by the funeral director, page 2 should be to	Completed							1 Yes	psy prid rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
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ision of V Attending Phys r death. rector: After thi	٦: T	27. Manner of Death		of Injury Day,Year)	28b. Time of I		y at Work?	28d Describe	how injury occurred	
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To the Hosp within 24 ho To the Fune completely fi	Medical C		Physician: To the best aminer:On the basis o and manner st	f examination a						
	ž	29b. Signature and title of certification of the second of		/ one	$\sqrt{2}$	29c. License O.C.N			29d Date signed May 2, 2006	(Month, Day, Year)
10	73	30. Name and address of person Theodore King MD.	Assistant Medi	•	,	nn Street, Bal	timore, MD 2	1201	•	
Sta	ate	31. Date filed (Month, Day, Year,		gistrar's Signati		20	·			

			1_ For State	State of Marylar	nd / Depa	artment o		d Mental Hy	giene	06	2
			Registrar 1. Decedent's Name (First, Middle, Las	**	06.	lincate	OI Dealli	2. Date of De	Reg. No.		3. Time of Death
	Physici	an						Month	Day		
	/Medic	cal	Helen (nmn) 4a. Facility Name (If not institution, give	Friel		4h City Tox	wn, or Location of D		29,	2006 County of Death	12:29 A ^M
	Examin	ier				Timon		Jean I		altimor	2
			Stella Maris Hos 5. Social Security Number 6. S		last birthday)	L		Hrs. 8. Date of Bit	1	9. Birth	place (State or Foreign
	uneral irector		103-22-2654	□M 21 76	Yrs.	Months D	ays Hours	Hrs. 8. Date of Bit (Month, Date of Cott.)	ay, Year) 21. 1	Cou	York
			Usual Residence of Decedent					1			
rylan	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits 1X Yes 2 ☐ No
е Ма	Sa-f s	cto	Maryland Harford	l Be.	l Air						
ith th	or 28	Dire	10e. Street and Number			10f. Zip Co			-	zen of What Cou	ntry?
within 72 hours after death with the Maryland	or tryliene. dothar than "netural; or items 23a or 28a-1 show avent. The Medical Examiner must be notified at	Funeral Director	338 Webster Stre			210			US		(
er de	items Def.	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Deceden If Yes, specify	t of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.))-	 Race - Ameri Black, White, 	
hours aft	r, or	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:		1□Yes 2🏻	No Specify:			Specify:	White
3 Por 3	eal E		15. Decedent's Ed	ducation	16a. Dece	dent's Usual C	ccupation		16b. Kir	nd of Business/Ir	
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d with	it Hyglene. othar than " vent. I've Me	Completed	12	Conege (1-401 5+)	Cler	ical				Manufac	turing
	vent	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden	Sumame)	
should be file	marked marked imatic a	10	James (unl	k) Pur	till		Hele	en (u	nk)	Мує	ers
Mar d 2 sho	r health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (or Rural Route Numb	-		
1 and	m 27		Ann Marie Lane -					Bel Air,			
Pages 1	° = °		20a. Method of Disposition 1 Burial 2 Cremation 3		cemetery, cre	osition (Name matory or othe	r place)	Date	20c. Lo	cation - City or T	own, State
	Uepartment of Importent: if if any injury or conce.		* 4 □Donation 5 □ Other (Specify			Serv. C		/02/06		son, Mai	
Dall permit.	Important in once.		21. Signature of Funeral Service Licer	1888	1		Address of Facility	McComas			•
0.0	12 6 G		23a, Part1, Enter the disease, or com	w				Road, Abir	_	, Maryla	
			shock, or heart failure. List only	one cause on each line.	^				111651,		Approximate Interval Between Onset and Death
	ysician Nedical		Immediate Cause (Final disease or condition resulting in death)	a		lula	febroar	come			5 MONTH
	aminer			Due to (or as a consec	quence of):	V					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):						
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9	been signed by the attending physician and should be detached for use as the burial-transit	cal	(d							
OX OO certifica	ng ph as th	Physician/Med	IF FEMALE:								
DOX	tendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐ Live birth 2☐ Feta		⊒Ectopic pregi	nancy		2	3d. Date of deliv Month	ery Day Year
. 8	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at time of o 9☐ Unknown	death 5[Other (speci	(fy)				 ,
T at the	d by letach	Phy	Part II. Other significant conditions of	contributing to death but not re-	sulting in the I	inderlying caus	se given in Part I	23e. Did	tobacco u	se contribute to t	he cause of death?
ords, P	signe I be d	i by	alt ii. Other significant contains	onthibuting to doubt but not to	Jaking in the c	indonying odd	o given in r air i.		Yes 26		bably 4 Unknown
HECOLUS he law requires	hould	Completed									opsy findings available
The law	has 98.2 s	mpl						24a. Was		prior to co	impletion of cause of
_ ⊢	certificate has birector, page 2 s		OF Management and to madical				00 Pl		2- No	1 Yes	2 □ No
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	er this eral d	H	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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L To the Hospitai	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin							
the .	the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c I	icense number		29d. Date	e signed (Month,	Dav. Year)
0	₹ 6 8		Da Reve	0.01			4714		11	101	
	. ^		30. Name and address of person who	1017	m 23a) /Tuna	5:0			3/	100	
	U			ell Ot/BVMC	1998 - 49 Y	D ER	Tenr A	Ve BAL	imol	Y MD L	1214
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign				1		-	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink

Steven Joseph		ces State	e of Maryla			f Heal	th an		Hygiene		20	na	11.21
Physici		Registrar 1. Decedent's Name (First, Middle,La	ast)		ranoato o	7 2001			2. Date of				3. Time of Death
Medical Exam		Steven Jose		'rances					Month April 30	Day 0, 2006	Yea	r	0445 hrs
		4a Facility Name (if not institution, g 1812 Elk Road	ive street and nu	mber)		4b. City, 1 Esse:		Location of De	eath		tc. County o Baltimore		nty
Funeral		Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)		er 1 Yea			f Birth (MN	M/DD/YYYY	9. Birth	place (State or
Director		218-08-1388	X M 2 F	20	Yr	Month s.	s Day	s Hours	Min. 5/1	3/19	85	Foreign Cou	^{ntry)} Maryland
any		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Loca	tion							10d. Inside City Limits
*			mo r co										1 Yes 2 X No
farylar 28a-f s at on	Director	Maryland Baltin 10e. Street and Number	nore		sex	10f. Zip	Code			10g. C	itizen of Wh	at Count	ry?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Memila Hygiene Important: If filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Ģ	1812 Elk Road	_				221				S. A.		
th with tems 2 st be n	Funeral	11. Marital Status 1 X Never Married 2 Marrie	Armed Fo						(Specify Yes o erto Rican, etc.)		14. Race White		an Indian, Black,
iter dez ", or i	Fu		1 Yes ed If Yes, Give Yea	2 X No	1	Yes 2	X No	specify:			Specify:	Whi.	te
ours af atural camin	d by	15. Decedent's Education (Specify	or Dates:		16a. Decede	nt's Usual	Occupat	tion (Give kind		16b	Kind of Bus		
6 n 72 h an "n ical Es	oleted	Elementary/Secondary (0-12)	College (1	-4 or 5+)			King ine	. DO NOT use	retired)				
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212 ould b d Men s marl	흔	19a. Informant's Name/Relationship	(Type, Print)	ances	19b. Mailin	g Address	(Stree	et and Number	or Rural Route	Number,	City or Towr	n, State,	Zip Code) 21128
MD nd 2 sh alth an m 27 i		Debbie Renee Fra	ances (M		8200) Fea	ther	Hill	Road P	erry	Hall,	, Mai	ryland
Ore, es l ar of Hez If ite		20a Method of Disposition 1 X Burial 2 Cremation 3	Removal fr		Place of Dispo crematory or of				Date 5/3		Location -		
time t Pag tment rtant:		4 Donation 5 Other Speci		Ga	rdens c	of Fa	ith	Cem.	5/3 2006	Ba	altimo	ore,	Maryland
Bal permi Depar Impo injur		21. Signature of Funeral Service Lic	ensee S II -		Bi	cuzdz	insk	i Fune	ral Hom	e PA	cov N	/arti	land 21221
Physician	m	23a. Part I Enter the disease, or or		used the death									Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on Immediate Cause (Final disease	a Hanging										Death
, and the		or condition resulting in death)		consequence of	of):								
New 10 ⁻⁸	-er	if any, leading to immediate	b. Due to (or as a	consequence of	of):							- 4	
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be executed sician and urial - transit	dical	UNPENDED	AMENDED										
6876C certificate l	ician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of preg		etal death	3	Ectopic pre	onancy	2	3d. Date of Month	delivery Da	ay Year
x 68 th cert ttendir	sicia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregr	ant at time of de		ther (Spe	cify)		,				,
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Vita hysicia this ce I direc	0 B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	it 3 🔲 🛭	OOA	Other Nu	rsing Home 5	Resid	dence 6	Other:	Scene
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Divisior To the Hospital or Attend within 24 bours after death. To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	ician: To the bes	st of my knowled	dge, death occu	urred at the	e time, da	ate and place,	and due to the	cause(s) a	and manner	as starte	ed
To the Hos within 24 h	Medical	one) 2 Medical Examin	er:On the basis and manner s	of examination a stated.	and/or investiga				ed at the time, o	date and p	lace, and d	ue to the	cause(s)
F > F 0	Ž	29b Signature and title of certifier	Q.M.)		29		e number					th, Day, Year)
0 4		John Un	194	las			O.C.	IVI. E.		A	oril 30, 20 	000	
2		 Name and address of person when Patricia Aronica-Pollak III 		se of death (Iter ant Medical	_ ′ .	111 P	enn St	treet, Baltin	nore, MD 21	201			
S	tate	31. Date filed (Month, Day, Year) MAY 0 5 20	00 32 Re	egistrar's Signat	ture	13.00							<u> </u>
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ОПИП Т/ Rev T/Z00T ОСМЕ 2006 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Angeline Ford 8:25 a May 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore** N/A Harbor Hospital Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5 Social Security Number **Funeral** Days 1 □ M 2**X**□ F 219-18-6014 87 Aug 3, 1918 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b County 10c. City. Town or Location 10a State Hygiene. other then "natural", or Itsms 23a or 28a-f show rent, the Moulcal Examinar name be notified at 1 X Yes 2 No Baltimore N/A Director Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 USA 221 Cedar Hill Lane Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 T Married Baltimore, Maryland 21215-0036 1 Tyes 2 No. Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Department Store Elementary/Secondary (0-12) Salesperson 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Unk Urias Brooks is marked ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 221 Cedar Hill Lane Baltimore, Maryland 21225 f Health a Itam 27 i Julius F. Ford Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If Its
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/06/06 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P.A. 1300 Eutaw Place Battimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ pe o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an hes autopsy performed? certificete 2 No 1□ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Cther: 4 Nursing Home 5 □ Residence 6 □Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 🗌 Yes death. investigation 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated December 2 Medical Examiner: On the basis of examination and/or investigation in my coloring death accurred at the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier D31/36 MAY 3 2006 ZIZSE KICBRIDE FARD, BATTURGE, ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 4005 ALL ACE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 5 Registrar MAY 0 2006

DHMH 17 Rev 1/2001

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			1 - For State Registrer	State of I	Marylar				ealth a			giene Reg. No.	006		214
ı	Physici	an	Decedent's Name (First, Middle, Las.	")							2. Date of De. Month	ath Day	Year		e of Death
	/Medic		BETTY ANN FABI								Mary	•	L 200	6 838	AM.
	Examir	er	4a. Facility Name (If not institution, give		ər)				Location		t	4c. C	County of De	ath	
			UNION MEMORIAL HO 5. Social Security Number 6. Se		Ane (In vrs	last birthday)		ALTIM or 1 Year	ORE (8. Date of Birt	th	N/A	irthplace (Sta	to or Fomica
	Funeral Director			_M 2⊠F	79	Yrs.	Months		Hours	Min.	5/20/19	y, Year)		ARYLANI	-
	and w		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside	City Limits
	Mary -1 eh	ţ	MD BALTIN	ORE		PARKVI	LLE							1 □ Y	es 2X No
	r 28a	Funeral Director	10e. Street and Number				10f. Z	p Code				10g. Citize	en of What (Country?	
	23a o	a D	8800 WALTHER BLVI	APT.	1113			212	:34			US	A		
	dea dea	Iner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Dec	edent of Hi	spanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	- 14	4. Race - An Black, Wh	nerican Indian	
36	or ft	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes		Specify:						
8	72 hours after death with the Maryland naturel', or iteme 23a or 28a-1 ehow disal Examiner must be notified at	pa p	15. Decedent's Edi	Year or Date	s:	16a. Dece	dont's He	ial Occupa	ation		1	16h Kin	d of Busines	WHITE	
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21215-0036	d within giene. ir then	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4	or 5+)	ВООК	KEEP	ER-AG	ENT			INS	URANCI	£	
	be filed stal Hygi od other event,	Bec	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maiden S	iumame)		
<u>ā</u>	should b ind Ments marked umatice	To	ALBERT MELCHOIR						ROBI	ERTA	E. REII	NHARD	T		
Maryland	2 shc and lem		19a. Informant's Name/Relationship (T			19b. Maili	ng Addres	s (Street a	and Numb	er or Rura	al Route Numbe	er, City or	Town, State,	Zip Code)	
6	of Health of Health litem 27 I		ROBERT THOMPSON/SO	N	205	1171 Place of Dispo			INT		FELTON		1732		
0	Pages nent of hont: If ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐		te _ C	RKWOOD	matory or	other place	_ '		/2006		IMORE	r Town, State	•
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		FA										D 4
Ba	permit. Departr Importe eny inju		21. Signature Tribian Service Electric								E JOHNSO /D. TOW:			поме, 1286	P.A.
8760,	Physician /Medical Examiner physicien and ph	Ical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or		うどう juence of):	dar	dre	are					Interval onset as 20	and Death
P.O. Box 68	The law requires that the death certificate be executed tie hes been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Feta at time of d	Ideath 3	⊒Ectopic p ∃Other (s					23	d. Date of d Month	elivery Day	Year
ds, P	w requires that been signed to should be deta	Ď	Part II. Dther significant conditions co	ntributing to deat	but not res	ulting in the u	nderlying	cause give	en in Part I		23e. Did to		/	to the cause of	
Š	v requ	ete									24a. Was			autopsy findin	
Вě	The lay	Completed									autop perfo		prior to death?	completion of	of cause of
ţ	ilan: ertifica etor.	Be	25. Was case referred to medical examiner?			·			26. Place	of Death	(Check only o				
<u>></u>	Physician: r this certifica ral director, p	10	1 Yes 2 No	Hospital: 1 / Inpa		ER/Outpatier	nt 3 D	OA Othe	er: 4 □ Nu	ursing Ho	me 5 Resid	dence 6	□Other (Sp	ecify)	
ם	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		28c. Injury Work			28d. Describe h	now injury	occurred		
Division of Vital Records,	of or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At he etc. (Specif		M reet, facto		fes 2□		28f. Location (S City or Tox		Number or F	Rural Route N	lumber,
	Hospite 24 hours Funerel	edical	29a. Certifier 1 Certifyin 3 Phyone) 2 Medical Exam	sician: To the be iner: On the basis and manner	of examina stated.	ition and/or in	vestigation	n, in my op	oinion, dea	ith occurr	ed at the time,	date and p	nd manner to place, and du	ie stuted ue to the caus	Θ(s)
	To the within To the comple	Σ	29b. Signature and title of certifier				29	c. License	number			29d. Date		nth, Day, Year	•
0	9		10.75 M.	W.			j	HT24	1389	46		Ma	72	2006	5
			30. Name and address of erson who c	ompleted cause of	f death (Iten	n 23a) (Type,	Print)	NY.	Has	pita	[M])	(
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2	32. Greg i	strar's Signa	ature A	2014	,	-(0)	+	1				

		1 - For State Registrar	State of Maryland / D	Department of He Certificate of De		Hygiene (16 14215
Physic /Med		1. Decedent's Name (First, Middle, Last) Janice Glaz	er		2. Date Mon		Year 006 11:00 A M
Exam Funera	iner	4a. Facility Name (If not institution, give st. 56 15 mc Kinley 5. Social Security Number 6. Sex	Street 7. Age (In yrs. last birth		f Under 24 Hrs. 8, Date	e of Birth	9 Birthplace (State or Foreign
Directo		Usual Residence of Decedent	10c. City, Town	Yrs.	Hours Min. (Mo.	nth, Day, Year) 3-1955	New York 10d. Inside City Limits
the Maryla 28e-f ehov	ector	10a. State 10b. County MD Montgo!				10g. Citizen of	1 Yes 2□No
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland to Montal Hygiene. marked other than "natural, or items 23a or 28e-f show imatic event, the Medical Exempler marked to marked other than "natural for marked other than "natural for marked other than marked other than marked other than medical Exempler marked other than the motified at	Funeral Director	5615 mc Kinley S	2. Was Decedent Ever in U.S. Armed Forces? 1 \(\triangle Yes \) 2 \(\triangle No \) If Yes, Give	13. Was Decedent of Hisp If Yes, specify Cuban,	nanic Origin? (Specify Ye Mexican, Puerto Rican, e Specify:	us A s or No- etc.)	ce - American Indian, ick, White, etc.
Maryland 21215-0036 ad 2 should be lited within 72 hours at tith and Mental Hygiene. It is marked other than "naturel; or reaumatic event; Ina Madical Event	Completed by	3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tion 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done dur life. DO NOT use retired)	on ing most of working	16b. Kind of E	Business/Industry
be filed tall Hyging of other	To Be Co	17. Father's Name (First, Middle, Last) Bennett Glaz		11	8. Mother's Name (First,	Middle, Maiden Sumai	
re, Ma 1 and 2: Health ar tem 27 is		19a. Informant's Name/Relationship (Typ Luca Barbone / Hus 20a. Method of Disposition	sband 56	Mailing Address (Street and 15 mc Kin ey) Disposition (Name of y, crematory or other place)	St. Betheso	la MD 208	City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: if item any injury or othe		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	moval from State Cheson	peake Cremate 22. Name and Address 933 Grist An	ory 5-4-06 of Facility Rapp F	Beltsvi uneral+cr	lle, MD emationservices 910
Physiciar /Medica Examine	1	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	not enter the mode of dying, $MCEM$			Approximate Interval Between Onset and Death
3760, ate be executed sysiclen and he burial-transit	Ical Examiner	Sequentially list conditions, Lary Lacing to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of				
. Box 68 death certifics e attending principle death use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)			ate of delivery onth Day Year
S, P.	5	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given	in Part I. 23	ie. Did tobacco use cor	atribute to the cause of death?
	Completed		- :			a. Was an 24b. autopsy performed? Yes 2 \(\times\) No	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 > 0
of Vital Re Physician: The t this certificate ha al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 □ Inpatient 2 □ ER/Out	tpatient 3 DOA Other:	26. Place of Death Chec	k only one) Residence 6 □Ot	her (Specify)
Sing I	Certification:	27. Manyer of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year) Ir		s 2 No	escribe how injury occu	
in Signature	Certif	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		Cit	y or Town, State)	ber or Rural Route Number,
To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my knowledge er: On the basis of examination and and manner stated.	dor investigation, in my opin	nion, death occurred at th	e time, date and place	nanner as stated. , and due to the cause(s) ed (Month, Day, Year)
7 × 5 0		· Patricia Tom	ske May, M	nd DS	1916	May	2, 2006
JU		30. Name and address of person who con Path I Ga Towsko To	Vay, 11119 Roca	Kville Pike,	6-100, Ro	ckville, 1	MD 20852
Regis	tate trar	MAY 0 5 200	6' France St.	poete	ŕ		

06-03000 Barbara Ellen Gahan

Please Type or Print in Black Indelible Ink

arbara Elleri Gai	1	State of Maryland / Department of Health and Mental H		g. No. 2006	14216
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle, Last) Barbara E. Gahan	2. Date of Death Month May 3, 200	Day Year	3. Time of Death 1635 hrs
Aller -		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		Riley's Marina 1901 Old Eastern Avenue Essex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s 8 Date of Birth	Baltimore Cou	
Funeral Director		217-34-7269 1 Months Days Hours Min		Foreig	
, any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	_	-	10d. Inside City Limits
Maryland 28a-f show d at once.	ے اق	MD Baltimore Essex 10e. Street and Number 10f. Zip Code	110	g Citizen of What Cour	1 Yes 2 X No
ith the Mar. 23a or 28a notified at	Ö.	131 Wiltshire Road 21221		USA	
r death wi	by Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes 2 X No specify:	Rican, etc.)	14. Race - Americ White, etc.	ite
hours a	ed ed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done tired)	16b. Kind of Business/li	ndustry
, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner traumatic event, the Medical Examines.	Completed	8th Homemaker		own home	<u> </u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ωl		e (First, Middle, M n Leist		
212 ould be I Ments mark ic even	E P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
e, MD 1 and 2 show Health and item 27 is rraumatic		John Gahan / husband 131 Wiltshire Roc	ad Balt	imore MD 20c. Location - City or	21221
2	- 12	1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 5	/9/06	Baltimor	
Baltimo permit. Page Department or Important: injury or out	- 1	21. Signature of Funeral Service Licensee, 22. Name and Address of Facility 30	00 Mace	Ave. Bal	to. MD
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Ussessor Ir jury that mitiated			
ted d ansit		events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED item#23a,27,28a-f,perME,g856,6/16/06	TT		
8760, tificate be ng physicias the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	nancy	23d Date of delivery Month	Day Year
Box 687 e death certific the attending p	Physician/	yes 12 Months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown 9 Unknown			
O. B at the d d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
S, P. uires th n signe	Completed by			2 No 3 Prob	
ord aw req has bee	plet		24a Was a autop: perfor	sy prior to d	topsy findings available completion of cause of
tal Recorcian: The law certificate has ector, page 2 sl	히	25. Was case referred to medical 26. Place of Death (Check	1 🗸 Yes 🛭		es 2 No
/ital	ă۱	everniner?		Residence 6 🗸 Other	Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death and the this certificate has been signed by led in by the funeral director, page 2 should be detach	آ: ا	27, Manner of Death 28a. Date of Injury (Month. Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sion Attend death ctor:	catio	Natural Accident Pending Investigation Investigation See. Place of Injury - At home, farm, street, factory, office building, etc.	unk	Street and Number or Pu	iral Pauta Number City
Divisual or /	Certification:	3 Suicide 6 X Could not be determined (Specify) Found: marina near home	Eastern A	Rivet and Number or Rutate) Riley's Market Lesex, MD	rina 1901 01d
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the caus	e(s) and manner as star	
To Yei	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (Mo	nth, Day, Year)
6		20. Name and address traceon who completed cause of death (Hem 23a)		May 4, 2006	
07		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
St	ate rar	31. Date filed (Month, Day Year) 22. Registrar's Signature MAY 0 5 2006			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** May 2,2006 7:20 A M JAMES LENNAN GRIMES, SR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 4, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 212-16-4309 84 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "natural", or items 23e or 28a-1 show other treumstic event. Its Modical Examiner must be notified at Baltimore 1 ☐ Yes 2 X No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with USA 21234 9405 Thornewood Drive Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Item 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Masonry Brick Layer 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie O'Connell John Tolley Grimes , Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lois Anne Bittinger-daughter 3598 Nicholson Road-Westminster, MD 21157 20b. Place of Disposition (Name of Pleasant Grove) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 Department of Important: If any injury or once. 5-4-06 United Methodist CHCam 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EVANS CHAPEL OF MEMORIES Road-Parkville, MD 21234 8800 Harford 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardial Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 No 1 Yes 2 🗆 No certificate To the Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 us) 6601 N. CHARLES STREET who completed cause weath (Item 23a) (Type, Print) 30. Name and address of 1 OWSON 31. Date filed (Month, Day, Year) 32 Segistrar's Signature . State 2006 Registrar

DHMH 17 Rev 1/2001

				yland / Depa	rtment of Heal	th and Mental	Hygiene Reg: No. 0 0 6	14218
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 3. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number)	G	tordon 4b. City, Town, or Loca	2. Date of Month	of Death	3. Time of Death A
	Funeral Director	Y	1DM 2DE	(In yrs. last birthday) 64 Yrs.			h, Day, Year) do	hplace (State or Foreign nuntry) YLAND
	r 28a-f ahow	Director		TOWSON	ation 10f. Zip Code		10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🙀 No suntry?
36	72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 ahow idical Examinar must be notified at	by Funeral D	1562 DELLSWAY ROAD 11. Marital Status 1 Never Married 2		_	ic Origin? (Specify Yes o exican, Puerlo Rican, etc ecify:		
Maryland 21215-0036	d within giene. r than	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 2 YEARS	(Give I	ent's Usual Occupation kind of work done during OO NOT use retired) EET ADMINIS	STOR	16b. Kind of Business/	
aryland	d 2 should be filed v th and Mental Hygie 7 Is marked other traumatic avent, IL	To Be (17. Father's Name (First, Middle, Last) JAMES L. GORDON 19a. Informant's Name/Relationship (Type, Pnnt)	19b. Mailin		LILLIAN W	liddle, Maiden Sumame) VILSON Jumber, City or Town, State, 2	Zip Code)
Baltimore, M	ges 1 an t of Heal if Item 2 or other		PICHARD M. FUN FA/FRIEND 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispos cemetery, crem	DELLSWAY Sition (Name of natory or other place) MATORY, INC	Date	I, MD 21286 20c. Location - City or CATONSVILL	
Balti	permit. Pag Department: Important: any injury o		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the	22.	Name and Address of 521 LOCH RA	Facility THE JOHN	NSON FUNERAL H TOWSON, MD 21	IOME, P.A. 286
	Physician /Medical Examiner				SHAL	Pheum	Efuno	Interval Between Onset and Death
8760,	cate be executed obysicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):				
.O. Box 68	The law requires that the death certificat tite has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tire 9 Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
Records, P	w requires that been signed t should be deta	Completed by Pl	Part II. Other significant conditions contributing to death but Acuse Reval Fai	not resulting in the un	nderlying cause given in		=1/4=2/s	o the cause of death? robably 4 Unknown utopsy findings available
Vital Re		Be Comp	25. Was case referred to medical examiner?	7) 10,74			autopsy prior to death? Yes 2 40 1 Yes	completion of cause of
Division of V	iing Phys n. After this funeral di	Certification: To	1 Yes 2 No Hospital: 1 Impatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28b. Time of	28c. Injury at Work? M 1 \(\text{Yes} \)	28d. Desc 2	Residence 6 □Other (Specifie how injury occurred	
Div	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Medical Certif	4 Homicide determined 29a. Certifier (Check only one) 29 Medical Examiner: On the basis of each one) 20 Medical Examiner: On the basis of each one) 20 Medical Examiner: On the basis of each one)	my knowledge, death	occurred at the time, da	City of the and place, and due to	or Town, State) o the cause(s) and manner as	s stated,
)	To the To the Comple	Mec	29b. Signature and little of certifier 29b. Name and address of person who completed tuse of dea	zh, u	29c. License nun	744	April 28	h, Day, Year)
	Sta Regist	ate rar	K. A. Kovich, aug L	Signature	idiral (Outer ;	soiso Pai	u Place

			1 - State Registrar	State of Mary	•	irtment of tificate of	Health and M f Death	lental Hygie	(UUb	14219
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici		Bernard A. Horne	2				A A A \ /	1-	06 21:36 PM
	/Medic		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Death		4c. County of I	De <i>a</i> th
			SAINT AGNES	HOSPI	TAL	BA	LTIMOR	ZE	I.	1/A
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Ye	ar) 9.	Birthplace (State or Foreign Country)
	Director		216-24-9506	M 2 F 77	Yrs.	Wieriting Buy.	J 110013 William	2/10/1	929	MD
	D >		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	anylan •how	<u> </u>	MD Baltin		o. Oxy, Town or Lo		altimore			1 Yes 2 □ No
	he M	Director	10e. Street and Number	юте	· · · · · · · · · · · · · · · · · · ·			100	Citizen of Wha	••
	death with the Maryland ms 23a or 28s-f ehow rnast be nutified at	늅	3233 Magnolia A	Venue		10f. Zip Code	21227	109.	USA	•
	Bath Na 23	Funeral		2. Was Decedent Eve	rin U.S. 13 1	Was Decedent of	f Hispanic Origin? (Spe	acify Yes or No-	,	American Indian,
	ter d	Ş	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No		Yes, specify Cu	iban, Mexican, Puerto	Rican, etc.)		White, etc.
	D36	þ	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	63-67	l□Yes 2□XN	o Specify:		Specify:	White
	2 ho	Completed	15. Decedent's Educa		16a. Deced	lent's Usual Occ	upation le during most of worki	165	. Kind of Busin	ness/Industry
	215 Pin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	OO NOT use retii	red)	ing .		
	21 Sign of the control of the contro	5	12	0		Postal				Force
	laryland 21215-0036 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "natural, or ite aumatic event, Tra Medical Exambles	Be	17. Father's Name (First, Middle, Last) Alexander Horn	ne.			18. Mother's Name	e (First, Middle, Maid t Mihm	den Sumame)	
	Via Meni	၉								
	Maryland 21215-0036 to 2 should be filed within 72 hours at the and Mental Hyglene. 77 Is marked other then "natural", or traumatic event, the Medical Exert.		19a. Informant's Name/Relationship (Type Robert M. John				et and Number or Rura		•	
	P, N I and tealth im 27 her t		20a. Method of Disposition		20b. Place of Dispo		_			ty or Town, State
	Baltimore, permit. Pages 1 ar Depertment of Heamportant: If Item moortant: If Item any injury or otherance.		1 🔀 Burial 2 ☐ Cremation 3 ☐ Re	1	cemetery, crer	natory or other p	lace)			
	tire treer treer treer		4 Donation 5 Other (Specify)	_						nsville,MD
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be fited within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehov any jointy or other traumatic event, the Medical Evantisat must be nutilitied at		21. Signatore of Funeral Service Licenses	Wictor D	oda	harles 501 E.	Iress of Facility L. Steve Fort Ave	ens Fune E. Balti	ral Ho more M	ome, Inc. MD 21230
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one		e death. Do not ent	er the mode of d	ying, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition	STREP	TOCOCC	AL PR	VEUMON	All		Onset and Death
•	/Medical		resulting in death)	Due to (or as a co		<u>.</u>				JA JA
	Examiner		Sequentially list conditions. b.							
	/ De ##	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a co	onsequence of):					
	8760, Cate be executed physicien and the burial-transit	хаш	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):					
(7)	8760, cate be exphysicien the buria	E		200 10 (01 40 4 01	51135 Q 51135 G 17.					
4	Cate phys	dical	d.							
Ż	cords, P.O. Box 6876(w requires that the death certificate be been signed by the attending physicis should be detached for use as the bu	Physician/Me	IF FEMALE:	c. If yes, outcome of p	pregnancy				23d. Date of	of delivery
al	Box eath cert attending	cian	in the past 12 months?	1 Live birth 2 4 Pregnant at tim	Fetal death 3	Ectopic pregnant Other (specify)	псу		Month	•
لله	P.O.	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	0.000	ouron (openny)				
Q	that the detail detail		Part II. Other significant conditions cont	ributing to death but n	ot resulting in the u	nderlying cause (given in Part I.	23e. Did tobac	co use contribu	ite to the cause of death?
-	ords, P.O requires that the seen signed by the hould be detached.	Completed by	CHRONIC OBSTRI	CTIVE	PULMON	ARY-	DISEASE	1 □ Yes	2 No 3	Probably 4 Unknown
HORNE	ecol law req es beer	ete						24a. Was an	24b. We	re autopsy findings available
Q.	Vital Rec	Ĕ						autopsy	prio dea	re autopsy findings available or to completion of cause of tth?
7	ifficet		25. Was case referred to medical			T	26 Place of Death	1 ☐ Yes 2 ☑ h (Check only one)	No IT	Yes 22 No
	of Vita Physicien: rthis certific	To Be	examiner?	ospital: 1 npatient	2 ER/Outpatier	1 3 DOA C)th or	me 5 Residence	e 6 ∏Other	(Specify)
	on of ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe how		
	indin ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Monar, Bay 7	oar) Injury		☐Yes 2☐No			
	Division of Vital Records, to Attending Physicien: The law requires taller death. Director: After this certificate hes been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, offic	e e	28f. Location (Stree City or Town, S	t and Number (or Rural Route Number,
	Ditel o									
	Division of Vital Rec To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	n occurred at the vestigation, in my	time, date and place, y opinion, death occurr	and due to the caus red at the time, date	e(s) and mann and place, and	er as stated. d due to the cause(s)
	To the complex	Me	29b. Signature and title of certifier	0 00			nse number	29d.	Date signed (/	Month, Dey, Year)
			- Compile	J. Wy		PI	8606	M	AY O	13,2006
	6		30. Name and address of person who com		h (Item 23a) (Type,	Print)				
	2		AJJAI ALV	A, 900 C	ATON A	VENUE	BALTI	MORE, M	1D 2	1229
	St. Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0.5 2006	37 Registrar's	Signature	we				

	1- For State C		partment of Health and I partificate of Death	Mental Hygie	4000	14220
	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Physician	Mary M. Ho	zmcKy		April 2	9, 2006	8:25 AM
/Medical Examiner	4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death		4c. County of Death	1-3-3
Examiner	6226 Alumore Was	1	Baltimore	1	N/A	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birthp	lace (State or Foreign
Director	214-30-5153 10M 28F	71 Yrs.	Months Days Hours Min.	September	6, 1934 Mari	yland
	Usual Residence of Decedent					
rrylar	10a. State 10b. County	10c. City, Town or			1	0d. Inside City Limits 1. Yes 2 □ No
Ba-f.s	Maryland N/A	Ba	ultimore_	.,		
with the Martor state of state of the mutilized	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	itry?
death with the Maryland ms 23a or 28a-f show ITHWELLE INTERING at	6226 Alumore Was		21224		USA	
fler death v	Armed F		 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
urs afte	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced 1 Yes, Gi Year or I	ve	1 ☐ Yes 2 No Specify:		Specify: Wh	140
hours af			and a Maria I Commention	1.40		
A I A I D-Ur ed within 72 ho ygiene. ner then "netur t, tre Medical	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation re kind of work done during most of wor . DO NOT use retired)	king	b. Kind of Business/Inc	dustry
withii ane.	Elementary/Secondary (0-12) College (1-4or 5+)	Waitress		Restaura	0+
be filed within 72 hours after that Hygiene dother then "neturel", or lite event, the Medical Erantra Re Completed by File	17. Father's Name (First, Middle, Last)	1		ne (First, Middle, Ma		
d be fill ontal Hyperen ceven	Bernard Tighe			a Dun		
re, INIAL yiang ZIZIS-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene. Health and Mental Hygiene. To Barked other then "neturel", or items 23a or 28a-1 show other traumatic event, the Medical Exact precrine the notified at To Barked Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street and Number or Ru			Code)
Mag saith and 2 saith and 2 saith and 27 ts	Rose Akram / Daugh		101	_	, MD 21:	
os 1 and of Health item 27	20a. Method of Disposition	20b. Place of Dis	position (Name of		c. Location - City or To	
Dallimory permit. Pages: Department of the Importent: if ite any injury or of once.	1 Burial 2 Cremation 3 Removal from		ifts Registry April		anover, M	
Dallino Dermit. Pages Department of mportent: If it any injury or once.	* 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Ligensee					
Depariment of the police of th	21. Signature di duniarai Service Elgensee		22. Name and Address of Facility And 522 Connelley D.	iatomy Git	is registry	NAN 21076
	23a. Part1. Enter the disease, or complications that				717,717	Approximate
	shock, or heart failure. List only one cause on	each line.	intel the mode of dying, such as cardiac	or respiratory arrest	· .	Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	ung (a)	1 cer			6 mon/hs
/Medical Examiner	Due to	(or as on insequence of):	c + c			1 0.
	Sequentially list conditions, b.	(or 36 a consequence of):	Smor ing			life
executed in and ital-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or sala consequence or).				
and and Il-trar	that initiated events c. resulting in death) Last Due to	(or as a consequence of):				
death certificate be executed death certificate be executed of for use as the buriat-transit fician/Medical Examir						
cate be physicial the burnal	d					
by the attending pletached for use as introduced for use as introd	IF FEMALE: 23c. If yes, ou	itcome of pregnancy			23d Date of deliver	101
bo bath c atten for u	in the past 12 months?	birth 2 🗍 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Day Year
the de ached	1 Yes 2 No 9 Unknown		Other (specify)			
GORGS, P.O. wrequires that the de been signed by the should be detached	Part II. Other significant conditions contributing to o	feath but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	ne cause of death?
ires ti			,,,,,	1. Yes	2 □No 3 □ Prob	ably 4 🗀 Unknown
The law requires that rate has been signed by page 2 should be determined by page 2.						Carlana and table
fec e law has l e 2 s				24a. Was an autopsy performe	prior to cor	psy findings available npletion of cause of
VICAL MEC sicien: The law certificate has t lirector, page 2 s					No 1 ☐ Yes	2□ No
ysicien:] ysicien:] is certifical director, p	25. Was case referred to medical examiner?		Other	th (Check only one)	-	
F F F F F	1 105 2010	Inpatient 2 ER/Outpati	ent 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how		1)
ding P	1 Natural 5 ☐ Pending (Mor	of Injury 28b. Time oth, Day Year) Injury		200. Describe now	mjury occurred	
Sicat ter: the	2 Accident investigation 3 Suicide 6 Could not be 389 Place	a of Injury . At home form		29f Location (Stron	et and Number or Rura	/ Pouto Number
DIVISION of tall or Attending P is after death. el Director: After ted in by the funer?	determined 200.1 lac	e of Injury - At home, farm, : ling, etc. <i>(Specify)</i>	street, ractory, office	City or Town, S		r ribate rvariber,
	29a. Certifier 1X Certifying Physician: To th	a hast of my knowledge de-	ath occurred at the time, date and place	and due to the servi	so(s) and manner as at	ated
he Hosp n 24 hou he Fune pletely fil	(Check only 2 Medical Examiner: On the b		investigation, in my opinion, death occu			
o the o the o the o the o the o the o the	29b. Signature and title of certifier	0	29c. License number	29d	. Date signed (Month,	Dey, Year)
⊢ ≯ ⊢ ŏ	N/land	V= I /ml	2 D712	75 /	35/21	126
0	30. Name and address of pareon who completed cau	se of death (Iron 222) (Time	Print)		W/01	104
2	DENIS MacDo WALD		Print) HU.DSONST R	BAITA 1	1D 21	224
State	10-14-01-11-1-	Registrar's Signature		-17010 1	2/	
Registrar	MAY 0 5 2006	aus B. A	sole)			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 _ State

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			Registrar				Cen	meate of	Deal	11		Reg. No.			
	Physici /Medio	al	RHODI	4 LIL	LIAN e street and number)	Rosi		HAMI 4b. City, Town,			2. Date of De.	ある a	QOO &		
	Examir Funeral Director	er	10000	Hampton Mumber 6. S 3273	Manor Nurs	ing Hot e (In yrs. last 90	ne	Fred of Under 1 Year Months Days	erick	C ler 24 Hrs.	8. Date of Bird (Month, Da 05-08	th y, Year)	Freder		
	land ow		10a. State	10b. County		10c. City, To	own or Loc	ation						10d. Inside City	Limits
	Mary Fied	to	MD	Frede	erick	Fre	ederi	ck						1 Tyes 2	2∕∑No
	n the	irec	10e. Street and Nur	mber				10f. Zip Code				10g. Citi	zen of What Co	untry?	
	23a c	alD	2408 E1	1sworth W	Vay #1A			2	21702	2			USA		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-1 show aumatic event, the Madrial Expendent must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ied 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give		lf lf	as Decedent of Yes, specify Cub	oan, Mexi	can, Puerto	ecify Yes or No Rican, etc.)	14. Rece - American Indian, Black, White, etc. Specify: White			
Ö	hour fural	ed b	2 X ANGOMEG	15. Decedent's Ed	Year or Dates:	16	Sa. Decede	nt's Usual Occu	pation			16h Ki	nd of Business/I		
21215-0036	n "na n "na Madio	Completed	(Spec	ify only highest gra			(Give k	ind of work done O NOT use retire	during m	ost of worki	ing	. 00. 10			
212	d with giene er the	Com	Elementary/5900	ridary (0-12)	4+	*/	Gui	dance Co	ounso	ler			School		
Maryland	al Hygie J other t	Be C	17. Father's Name	(First, Middle, Last)					18. Mo	ther's Name	(First, Middle,	Maiden	Sumame)		
<u>S</u>	should be and Mental is marked o	Tol	Rheinho	ld A. Ros	en					01ga	Peters	on R	osen		
a				ame/Relationship (1							Town, State, Z		
	and lealth m 27 her tr			amilton/s	son 	Joh Blace			th W		A Frede		MD 217		
0	ges 1 If of H If Ite or ot		20a. Method of Disp 1 Burial 2		Removal from State	ceme	tery, crema	ition (Name of atory or other pla Services	ice)	1			cation - City or 1		
altimore,	permit. Pages 1 an Department of Heal Important; If Item 2 any injury or other once.			5 Other (Specify		the	Heal	th Scien	CCE	05-0	02-2006	В	eltsvil	le, MD	
Ba	Departing Department of the policy of the policy is the policy of the po		21. Signature of Fu	neral Service Licen		1200	Ra	app Fune	eral	& Crei	mation	Serv	ice		
		/A 1	23a, Part1, Enter th	ne disease, or com	plications that caused	the death. D		33 Gist					20910	Approximate	
Part In	Physician /Medical Examiner		shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only Final	a. Due to was	keene	er:	& Ty		2020				Interval Betwee	eath
	executed in and ial-transit	Examiner	Sequentially list configure, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) I	injury	b. Due to (or as a Due to (or as a	·									
ox 68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	n/Medical	IF FEMALE:		d23c. If yes, outcome	of pregnancy									
P.O. Bo	res that the death is signed by the atten be detached for u	Physician	23b. Was decedent in the past 12 1 ☐ Yes 2 ♥ 9 ☐ Unknown	months?	1⊆Live birth 4⊟Pregnant at 9⊟ Unknown	2 Fetal dea	ith 3 □ E 5 □ (Ectopic pregnand Other (specify)	У				3d. Date of delik Month	Day Ye	ar
	w requires that been signed should be def	by		Film.	ontributing to death but	n ·		derlying cause gi	ven in Pa	rt I.	23e. Did to		se contribute to	the cause of dea bably 4 DUn	
Il Records,		Completed							· - · · · · · · · · · · · · · · · · · · ·				24b. Were aut prior to co death?	opsy findings avompletion of cau	railable use of
Vita	Physician: rthis certifica ral director, i	Be	25. Was case reference examiner?	/	Hospital:			10			(Check only o				
ot		To.	1 Yes 2 2		1 Linpatie		Outpatient of	3 DOX					Other (Spec	ify)	
Division of Vital	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filted in by the funer	Certification:	1 Accident 3 Suicide	5 Pending investigation 6 Could not be			Injury		ry at ork?]Yes 2	□No	28d. Describe h				
N O	urs after or A		4 Homicide	determined	28e. Place of Inju	:. (Specify)					City or Tou	m, State)			37,
	the Hosp hin 24 ho the Fune	Medical	опе)	2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	ige, death and/or inve	stigation, in my	opinion, d	leath occurre	ed at the time,	date and	place, and due	to the cause(s)	
	To You'd	-	29b. Signature and	A / 3	nd 1	44.1	110	29c. Licen		395		M	signed (Month)	Day, Tear)	
	26		WE	ellan	26 CUL	vec).	ul!		406	270		MC	145,	2006	
	8)		Willia	mH.	completed cause of de	x 19	a) (Type, P	Thom	45	John	son D	<u> </u>	Tred mari	ericky a	2170
	Sta Registr		31. Date filed (Mon	MAY 0 5 2	32. Tegistra	r's Signature	1	and a					0		

or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Box 68760, P.0. ate has been signed by the a page 2 should be detached. Division of Vital Records, certificate has director, Pis funeral After t death. the Director:

p-m-

11:50

Amend Item 23a per Dr., G855, O5730/Ucdhb 1 - For State Registrar ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 50PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (not institution, give street and number, Examiner 7. Age (In yrs last birthday) IIMONIU more If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Date of Birth 6. Sex **Funeral** Months Days Hours 1 M 2 M F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c, City, Town or Location 28a-f ehow the Madical Examiner roast be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or SA 12. Was Decedent Ever in U.S Armed Forces? 1 Pes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ltems ; 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 6 1 Yes 2 No Specify: White Specify δ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (3-4or 5+) Elementary/Secondary (0-12) Homemake injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be for Olive Pronica Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is many injury or other 20b. Place of Disposition (Name of cemetery, crematory or other to Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State memoral Garden Ilmonium, mD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Conses 22. Name and Address of Facility Evans Funeral chapel- in Ar Dr 21050 Millette 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Pneumonia Immediate Cause Final disease or condition resulting in death) Physician END STAGE DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 **Y**Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA HOSPICE 10 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funeral Direct 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier 29c. License number 43721 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TARIQ MAHMOOD 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10c per fh 2835 5-5-06 vt.

State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 **Physician** =LEANOR 2006 01 /Medical acility Name (If not institution, give street and number) 4b. City-Town, or Location of Death 4c. County of Death Examiner TIMORE 9. Birthplace (State or Foreign Country) VCRK Social Security Number 6. Sex 7. Age (In yrs. last birthday) Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Davs Hours Min. 216-30-563 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits orient: If item 27 is marked other than "natural", or items 23a or 28a-1 show Injury or other traumatic event, the Madical Examinar must be notified at Nottingham BALTIMORE 1 Yes 2 No Director mn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 AUE 21236 USA 4102 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ 100 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene important: if Item 27 is marked other than any Injury or other traumatic event, the Magnes, and pigge. College (1-4or 5+) Elementary/Secondary (0-12) 12 ECRETAR Company LITLE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be HERMAN BRODSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Retal Route Number, City of Town, State, Zip Code) rarkulle GUEYDAN DONNA -DAU MD Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 209 Location - City or Town, State Pages ' may 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) D CEMETERY 22. Name and Address of Facility MARKUILLE TARKWOOD 4,2006 mD 21. Signature of Funeral Service Licens 8800 HARFORD RU. CHAPEL VARKUILE TUNERAL MO Q1234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** piratory /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9□ Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 N No 250 No 1 🗆 Yes Division of Vital 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 24 No 2 ER/Outpatient 3 □ DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 5 Pending death. 1 □ Yes 2 □ No 2 Accident investigation M I or Attend after death Director: / completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ame and disess person who impleted cause of death (Item 23a) (Typ», Print) T. Date filed (Month, Day, Year) 32. A strar's Signature State

Registrar

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		•	1- For State of Maryland /	Department of Health and M Certificate of Death	lental Hygier	.000	14224
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		BLANCHE EDNA HO	NIG	MAY 1,	2006	1:15 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
1			126 CITY VIEW AVE.	WESTMINSTER		CARROLL	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	ar) Cou	place (State or Foreign ntry)
	Director		213-05-1645 88 Usual Residence of Decedent	Yrs.	10/10/1	917 MAR	YLAND
	and and		the contract of the contract o	wn or Location			10d. Inside City Limits
	Mary -f sh	ţ	MD CARROLL WE	STMINSTER			1 ☐ Yes 2 X No
	r 28a	rec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	h with	0	126 CITY VIEW AVE.	21157	τ	JSA	
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show he Madicel Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,	
9	after or its	丑	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	riicari, etc.)		
21215-0036	ours iral',	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	12 103 2,5 100 Specify.		Specify: WH	LTE
5	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) 	ng 16b	Kind of Business/Ir	ndustry
12	within	E D	Elementary/Secondary (0-12) College (1-4or 5+)	V-1004			- ID
2	Hygie Ther	ပိ	1.2 17. Father's Name (First, Middle, Last)	HOUSEWIFE 18. Mother's Name	(First, Middle, Maio	OME MAKE	SK
an	d be antal	o Be	RAY C. GREEN		MAY STO		
<u>></u>	shoul nd Ma mari	၉	19a. Informant's Name/Relationship (Type, Print)	Db. Mailing Address (Street and Number or Rura	ul Route Number, Cit	y or Town, State, Zij	Code)
Ž	nd 2 alth a 27 is		DOUGLAS S. HONIG - SON 1	126 CITY VIEW, WES	TMINSTER	, MD. 21	1157
Baltimore, Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Mardical Examinar must be notified at once.		cemet	of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or To	own, State
Ë	Page nent c int: If				/4/06 FI	NKSBURG,	, MD
alti	mit. partri porta y inju		21. Signature of Feneral Service Licensee	22. Name and Address of Facility FL	ETCHER F	UMERAL H	HOME
œ	80E 8 8		* (Y)(1)	254 E. MAIN ST.,	WESTMIN	STER, MI	21157
			23a. Part1. Er ter he disease, or complications that caused the death. Do shock, of he in failure. List only one cause on each line.	20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN MEM.GARDENS 5/4/06 FINK 22. Name and Address of Facility FLETCHER FUN 254 E. MAIN ST., WESTMINST.			Approximate Interval Between
	Physician		Immediate Ca e (Final disease or condition	ASCIN .			Onset and Death
4	/Medical Examiner		resulting in death) Due to (or as a consequence	e of):			0
	Lamine	_	Sequentially list conditions, b.				
	ed isit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	9 01			
6	xecut and II-tran	xan	that initiated events c. Due to (or as a consequence	e of);			
,160,	Attending Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.						
687	tificate ng phys as the	by Physician/Medical	0.				
Вох	eath certific attending pl for use as t	N/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv-	ery
ĕ.	that the death cer ed by the attendir detached for use	cia	in the past 12 months? 1 Ves 2 M/No 4 Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	if the d by the tached	hys	9 □ Unknown				
S, F	ss tha	y P	Part II. Other significant conditions contributing to death bul not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
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မင္မ	e law re has be je 2 sh	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
E	The ate h page	Son			performed 1 ☐ Yes 2 ☐	? death?	2 □ No
ita	cian: ertific	Be	25. Was case referred to medical examiner?		(Check only one)	7,1,	
7	hysi this c	ို	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing Ho		6 ☐Other (Special	fy)
Š	ing F	inol	1 Natural 5 Pending (Month, Day Year)	Injury Work?	28d. Describe how in	ilury occurred	
isio	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,		28f. Location (Street	and Number or Run	al Pauta Number
Division of Vital Records,	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	ann, street, factory, onice	City or Town, St.		ar noute Number,
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	HO 124 h 16 Fui	Medical	(Check only 2 Magical Examiner: On the basis of examination and manner stated.	nd or investigation, in my opinion, death occurr	ed at the time, date a	and place, and due t	o the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
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	Sta Registr	200	31. Date filed (Month, Day, Year) 32 Registrar's Signature N1AY 0 5 2006	Dark)			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death **Physician** Month 5:45 AM JACOB HAYES 28 2006 pril /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 18, 1948 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 ☐ F No. Carolina 236-82-1891 57 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "naturel", or Iteme 23a or 28e-f ehow vent, the Medical Examiner must be notified at X 1 ☐ Yes 2 ☐ No Baltimore Maryland N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21225 940 Stoll Street filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 → No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Trucking Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be . Pages 1 end 2 should be fil tment of Heelth end Mentel H tant: if Item 27 is marked ott lury or other treumatic even Lavenia Williams Hayes Jacob Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Stoll Street Baltimore, Maryland 21225 Darlene Hughes Hayes Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. 05/06/06 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Name and Address of Facility
 Estep Brothers Funeral Service, P. A.
 1300 Eutaw Place Baltimore, Md 21217
 ath. 1300 Eutaw Place Baltimore, Md 2 23a. Part1. Ent. The disease or complications that caused the death. It shock, or his rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstructive Physician pulmonory /Medical Examiner esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed best Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ neumomo 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes 1 Yes 2 No 25. Was case referred to medical funeral director 26. Place of Death Check only one examiner Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury deeth 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funarel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Cebotary 29c. License number 29b. Signature and title of certifier Valeriu 29d. Date signed (Month, Day, Year) 222 745 April 28, 2006 Cefotore, M.A. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21225 street, South Hanover 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

			1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 14 2 2 6
	Physi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 4 25 2006 1 22 1 PM
	/Med Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Softmark City
NP	Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1 Hearth Day, Year) 1 M 2 X 55 Yrs. 1 Months Days Hours Min. 1 Month Day, Year) 1 M 2 X 55 Yrs. 1 Months Days Hours Min. 1 Month Day, Year)
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ウエ	death with the Maryland ms 23a or 28a-f ehow	Director	10e. Street and Number Apt. E 10f. Zip Code 10g. Citizen of What Country?
a		Funeral	2506Edge Comb Circle North 212.5 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Rend Forces? 14. Race - American Indian, Black, White, etc.
3	036 ours after ref., or its	þ	1 Never Married 2 Married 1 Never Married 1 Never Marrie
03	1215-0036 within 72 hours atter ene. then "naturel", or lite he Maulical Examples	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Setendary (0·12) College (1·4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
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+	Maryland id 2 should be file th and Mental Hy 77 Is marked oth traumatic event	70 E	Jacob P. Drafts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zid Code)
242	ste, Ma		Vandella Hoyes Daughter 2506 Edgecomb Crole, Batto MD 21215 20a. Melhod of Disposition Date 20c. Location - City or Town, State
8	0 0 0 = =		1 Daurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Commetery, crematory or other place) MH. Zion Cemetery 5 5 06 Baltimore, MD
	Baltim permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Licensee Liver Services 12. Variety of Funeral Services 12. Variety of Funeral Services 12. Variety of Funeral Services 12. Variety of Funeral Services 12. Variety of Funeral Services 12. Variety of Funeral Services
	Dhuaisia		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
	Physician /Medica Examine	ıl	disease or condition resulting in death) a. Due to (or as a consequence oil):
	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
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	Division of Vital Records, P.O. Box 68 for attending Physicion: The law requires that the death certifica effer death. Director: After this certificate hes been signed by the attending phy in by the funeral director, page 2 should be detached for use as it	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	dS, P. ires that i signed by d be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 20 Probably 4
	ecord law requires best been seen seen seen seen seen seen seen	Completed	24a. Was an autopsy findings available prior to completion of cause of
	of Vital Rec hysicion: The law his certificete hes I	0	performed? death?
	of Vi hysicle his cert	ToB	examiner? 1 Types 2 No Hospital: 1 Inpatient 2 FeVoutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	ion of nding Phy ath. r: After thi	atlon:	27. Manner of Death 15 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Set. Injury at Work? 1 Texhatural 5 Pending 2 No Month, Day Year) 1 Texhatural 5 No Month, Day Year) 28d. Describe how injury occurred 28d. Describe how injury occurred
	Divisio To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State)
	the Hospital or nin 24 hours effe the Funerel Dir npletely filled in	ledical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Consider the time, date and place, and due to the cause(s) and manner as stated.
	To the within To the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ModAhaw D. Smith Smai Hospital of Baltmore
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	Regi	State strar	MAY 0 5 2006

DHMH 17 Rev 1/2001

06-02978		Please Type or Print in Black Indelible Ink	
Deborah Thomas	Jo		1100
		1- For State Registrar Certificate of Death Reg. No. 2006	1422
Physicia	_	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3	3. Time of Death
Medical Examin		Deborah Thomas Jones Month Day Year May 2, 2006	1524 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		3202 Presbury Street Baltimore	1
			place (State or
Funeral Director		Months Davs Hours Min. AA Foreign	0.0.1
Director		2/4-56-9862 1 M 2 XF 53 Yrs.	itry) / V.a.
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any			Od. Inside City Limits
nd show	<u>_</u>	Maryland NIA Raltimore	1 XYes 2 No
aryla 8a-f	ector	10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr	y?
or 2		13202 Preshury St 21216 USA	
ith the 23a noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	en Indian Black
th w	Funeral	1 Never Merried 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	ar maiari, biack,
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5-0036 led within 7 Hygiene. other than	Completed	11 DIETARY AIRE HORNS HOP	Kins Hosp.
5-C		17. Father's Name (First, Middle, Last)	9
21 be fill nital F	a	James M. Jones Violet Kobertso	n
ould I	ည	19a. Informant's Name/Relationship (Type, Print) Father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2	Zip Code)
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. icm 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Mr. James Jones 13202 Preshury St. Balto M.	d. 21216
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To	own, State
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other place)	L ANI
ti Pa		4 Donation 5 Other Specify: IVI, CONVE	K, Ma.
Balti permit. Departi Import		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. Russ Funeral Home, F	P.A.
		1 Della Di Alla 12222 W. North Ave. Baito, Md. 2	21216
Physician		23a. P the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart figure. List only one cause on each line.	Approximate Interval Between Onset and
/Medical	2 4	Imme late Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Death
*Aaiiiiiei		or condition resulting in death) Due to (or as a consequence of):	
		Sequentially list conditions, b.	
	ē	if any, leading to immediate Due to (or as a consequence of):	
	Ē	(Disease or injury that initiated	
ed	Examiner	events resulting in death) Last Due to (or as a consequence or):	
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be er siciar	ğ	UNPENDED	
68760, certificate bounding physic	ž	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Polymer A February 3 February 3 February 22d. Date of delivery	
68 certif	a.	past 12 months?	y Year
Box e death c the atten	Sic	1 Yes 2 No 9 Unknown Unknown 9 Unknown	
he de	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	a cause of death?
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici uneral director, page 2 should be detached for use as the burn	þ	1 Yes 2 No 3 Probal	
S, P. irres th			
requiponal	Completed	24a. Was an 24b. Were auto autopsy prior to co	psy findings available mpletion of cause of
e law	E	performed? death?	
freat The	ပိ	1 _ Yes 2 ✔ No 1 _ Yes 25. Was case referred to medical 26. Place of Death (Check only one)	2 No
of Vital Records, g Physician: The law require then this certificate has been s neral director, page 2 should	Be	examiner?	
Nysi Viysi	ပ	1 Yes 2 No Traing tions 3 Residence 6 Order.	Scene
fing Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
tend cath	atic	7 Natural 5 Pending 1 Yes 2 No	
Division pital or Attendi ours after death teral Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura	Route Number, City
Di Di al la la la la la la la la la la la la	erti	determined (Specify)	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the this certificate has been signed by the attending physici phetely filled in by the funeral director, page 2 should be detached for use as the burn.			d
To the Hos within 24 h completely	lica	(Check only one) 2 Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	
To the vithin To the comple	Medical	and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Monte	h. Dav.Year!
	_	O.C.M.E. May 3, 2006	/,/
		0.0.IVI.E. IVIdy 3, 2006	
0 ,		30 Name and address of person who completed cause of death (Item 23a)	
£		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	NETTY OF THE SECONDARY OF	
Regist	rar	MAY 0 5 2006 Programme A State of the State	

		State of Maryland / For State Registrar	Depa	artment of Health and Martificate of Death	Mental Hygi	_	14228		
Physicia: /Medica	n	1. Decedent's Name (First, Middle, Last) ELIZABETH M.		JONES	2. Date of Death MONTH 2,	2006 Yes	3. Time of Death 9:10 AM		
Examine		4a. Facility Name (If not institution, give street and number) GENESIS HERITAGE NURSING CENTER		4b. City, Town, or Location of Death		4c. County of D	eath LTIMORE		
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 型 F 7. Age (In yrs. last. 1 □ M 2 型 F 91 Usual Residence of Decedent	birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1–23–19	Year)	Birthplace (State or Foreign Country) MARYLAND		
e Maryland	ctor	10a. State 10b. County 10c. City, To MD BALTIMORE	own or Lo	RASPEBURG			10d. Inside City Limits 1 ☐ Yes 2 No		
3a or 28	II Director	10e. Street and Number 4605 VALLEY VIEW AVENUE		10f. Zip Code 21206	10	g. Citizen of What U.S.A.	Country?		
72 hours after deeth with the Maryland natural, or Items 23a or 28a-f show ore Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Prican, etc.) 14. Racc Blacc Specify		merican Indian, /hite, etc. WHITE		
within within then.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) HOMEMAKER	sing 1	6b. Kind of Busine			
TIO Ital H od otl	To Be Co	17. Father's Name (First, Middle, Last) CHARLES EDWARD	WI	LSON CARO	ne (First, Middle, M	aiden Sumame) (DIET	RICH)		
Maryla d 2 should In and Men 7 is marke traumatic	1			ng Address (Street and Number or Ru. EDGEDALE ROAD	ral Route Number, PARKVILL	•	e, Zip Code) 21234		
other		20a Method of Disposition 20b. Place	of Dispo	osition (Name of matory or other place)	Date 2	0c. Location - City			
Datumore, permit. Pages 1 a Department of Hea Importent: If Item eny injury or othe once.			2	EMATORY 5-6 Name and Address of Facility CV 1211 CHESACO AVEIN	ACH/ROSED	ATONSVIL PALE FUNE EDALE, M	RAL HOME		
re be ysicie	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Estock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the c	ce of):	ARTERY AL HYP	DISE	ASE	Approximate Interval Between 15 EAC 2 STEAR		
the death certificate y the ettending physiched for use as the		Physician/Medi	ysiclan/Medi	ysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of Month
w requires that the de been signed by the eshould be detached to		Pad II. Other significant conditions contributing to death but not resulting the RALL XASCU	g in the u	nderlying cause given in Part I.		. /	e to the cause of death? Probably 4 □Unknown		
	Completed by					ed? prior deatl	a autopsy findings available to completion of cause of n? Yes 2 \(\sumbolea\) No		
	Certification: To Be	25. Was case referred 6 medical examiner? 1 Yes No	b. Time o	ont 3 DOA Other: 4 Fursing H If 28c. Injury at Work? M 1 Yes 2 No	th (Check only one ome 5 Resider 28d. Describe how 28f. Location (Strr City or Town,	once 6 Other (S	Specify) r Rural Route Number,		
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	edical Cer	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	dge, deat	h occurred at the time, date and place	, and due to the car	use(s) and manne	r as stated. due to the cause(s)		
To the within 2.	Med	29b. Signature and title of certifier	0	29c. Nicense number	,	d. Date signed (M			
6		3) Man and address of secson one popular cause of death (Hem, 2)	a) Type,	Print 410-A R	LITCH	IE HI	GHWAY,		
Stat Registra		31. Date filed (Month, Day, Year) MAY 0 5 2006 Registrar's Signature	Age	HUIMOR	E,1	171-/6/	9MD 21225		

		State of Maryland / Department State of Maryland / Department Certificate		ental Hygien	C U U C	14229
Physici /Medie	cal	1. Decedent's Name (First, Middle, Last) NORMAN Kindell, Jr.		2. Date of Death Month Da	ay Year 2006 c. County of Death	3. Time of Death
Funeral Director	ner	Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 Months Months	Year If Under 24 Hrs.	B. Date of Birth (Month, Day, Year	Balt	none Courty place (State or Foreign
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Modical Example must be notified at ance.	To Be Completed by Funeral Director	1 Pes 2 No 3 Widowed 4 Divorced If Yes, Give 1 1 Yes 2 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondar (0-12) To Father's Name (First, Middle, Last) Norman H. Kindell Specify Print) 19b. Mailing Address	County Code 21244 ant of Hispanic Origin? (Specify Cuban, Mexican, Puerto R WNo Specify: Occupation & done during most of working a retired) 18. Mother's Name Max (Street and Number or Rural	ify Yes or No- ican, etc.) 16b. I (First, Middle, Maide Route Number, City	14. Race - Ameri Black, White, Specify: AFN Kind of Business/Ir an Sumame)	can Indian, etc. Tem Amental dustry
permit. Pages 1 and Department of Healtl Important: If Item 2: any injury or other t		20a. Method of Disposition 1 We Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	e of Da	1,2006 E	Location - City or T	own, State
death certificate be executed death certificate be executed Wedical Example of for use as the burial-transit	edicai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Saturation list consons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. MENAL FAILURE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	NFARCTION			Approximate Interval Between Onset and Death
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnant at time of death 9 ☐ Unknown			23d. Date of deliv Month	ery Day Year
The law requires thet the ate hes been signed by the page 2 should be detached.	[출	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	1	ouse contribute to a	he cause of death?
nysician: The law requires t nis certificele hes been signe i director, page 2 should be	e Completed	25. Was case referred to medical	OF Place of Positi	24a. Was an autopsy performed? 1 Yes 2 N	prior to co	opsy findings available impletion of cause of 2 No
a the	Certification; To Be	examiner? I \(\text{Yes} \) 2 \(\text{No} \) No Hospital: I \(\text{Inpatient} \) 2 \(\text{ER/Outpatient} \) 3 \(\text{DO} \) 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 2 \(\text{Accident} \) 4 \(\text{Notion of Injury} \) M	3c. Injury at 21 Work? 1 Yes 2 No	e 5 Residence	ury occurred	
Hospitel or 4 hours afte Funerel Din 18ly filled in I	edical Certific	4 Homicide determined determined 298. Place of injury - All nome, farm, street, factory, building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, ar	8f. Location (Street a City or Town, Sta and due to the cause d at the time, date an	(s) and manner as	stated.
To the within 2 To the complet	Med	and marrier states.	License number	29d. D	Date signed (Month,	Dey, Year)
2 Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cosmo Jawas no, 4001 Liberry II. 31. Date filed (Month, Day, Year) MAY 0 5		BALTIMO	, ,	21207

State of Maryland / Department of Health and Mental Hygiene

CATON AVE

AGNES

32. Registrar's Signature

900

BALTIMORE MD 21229

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylan	•	artment of I			giene Reg: No.	6 14231	
	Physici	an	Decedent's Name (First, Middle, Last) SHIRLEY		νn	WITZ		2. Date of Dea	Day	Year 3. Time of Death	M
	/Media		4a. Facility Name (If not institution, give st	reet and number)	NUI		or Location of Death	MHA.	02 · 28	1/1/	VI
	Examir	ier	JEWISH CONVALESCEN			BALTIM				TIMORE	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days		8. Date of Birt	h V. Year)	Birthplace (State or Foreign Country)	_
	Director		219-88-5880 1 LI Usual Residence of Decedent	M 2 X F 86	Yrs.			03/19,	1920	POLAND	
	ehow		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limit	s
	B-f eh	tor	MD BALTIM	IORE	OWING:	S MILLS				1 □ Yes 2 🕅 N	0
	72 hours after death with the Maryland natural', or items 23a or 28a-1 ehow disal Examinet must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	•	
	s 23a	rai	4730 ATRIUM WAY #1				21117		11.5	USA	
	items	une	11. Marital Status 1. Never Married 2 Married 1. Never Married 2 Married 1. Married 1. Never Married 1. Nev	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No 	S. 13. V	Vas Decedent of f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Had Blad	e - American Indian, ck, White, etc.	
036	urs af	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2XX No	Specify:		Specify	wHITE	
21215-0036	72 ho	Completed	15. Decedent's Educ	ation completed)	(Give	lent's Usual Occu kind of work done	during most of work	ina	16b. Kind of B	usiness/industry	
121	within ene. then *	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMA	DO NOT use retire	nd)		OWN HO	ME	
	filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)		HOHLIN	TILL	18. Mother's Name	e (First, Middle,			
lan	Mental Merked o	To Be	SHMUEL		SCHNE	I DERMAN	RIVKAH			APPLEROI	D
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Typ				t and Number or Run		-		
-	is 1 and of Health item 27 other tr		ERVIN KOWITZ / SON	-		SITION (Name of		- REISIE		MD 21136 City or Town, State	
nor	8 2 = 5		1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	emetery, cren	natory or other pla TEFIORE	ice)	4/2006		HORPE, MD	
Baltimore,	P. Parts at		21. Signate Funeral Service cense	17		. Name and Addr				ROS., INC.	
ä	Dep. Imp.		XIII Chall to	mon	89	900 REIS				LE, MD 21208	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	Physician		Immediate Cause (Finaf disease or condition resulting in death)	Congestive	re of	Jeest	Julia	e		Onset and Death	l
	/Medical Examiner		resulting in dealin)	Due to (or as a consequ	uence of):	21/22	I dise	218		7/month	ù
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	ce of):	2	4 000,00			7 O 22-10 Sa	
$\sqrt{}$	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
0	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
8760	icate be e physician s the buria	dicai	d.								_
9 X	leath certific attending p I for use as i	/Med	IF FEMALE: 23	c. If yes, outcome of pregna	ncv				22d Da	te of delivery	
Box	death a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 moorns? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify) _	y		Mo		
P.0.	at the de by the a tached f	hys	9 Unknown	9□ Unknown							
	res tha igned I be det	by P	Part fl. Other significant conditions cont	ributing to death but not resu			ven in Part I.	-		ribute to the cause of death?	
ord	w requir been si should	ted	The ruge	COMEDAS	wou	1 uc/	10170	101	/es 2□No	3 ☐ Probably 4 ☑ Onknow	'n
Vital Records,	e law has b	Completed						24a. Was autop	sy	Were autopsy findings availab prior to completion of cause of death?	le
al	sician: The certificate harector, page	e Co	25. Was case referred to medical					1 ☐ Yes	212 No	1 ☐ Yes 2 ☐ No	
<u>=</u>	ysicia Is cert directo	To B	examiner?	spital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3DDOA Ot	26. Place of Death		<i>ne)</i> dence 6 ⊟Oth	er (Specific)	
J Of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			now infury occur		
sion	utsndir death. ctor: Af y the fu	catic	2 Accident investigation			M 1	Yes 2 □No				
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre /)	et, factory, office		28f. Location (5 City or Tov		er or Rural Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best of my know	wledge, death	occurred at the t	me, date and place,	and due to the	cause(s) and ma	nner as stated.	
	the H hin 24 the F	Medical	one)	or: On the basis of examinat and manner stated.	non and/or my						_
	To with	~	29b. Signature and title of certifier	5			se number	($0.3 \cdot 2006$	
	3		30. Name and addr-us -f person who con	npleted cause of death (Item	23a) (Type, I	Print)	re aure	RUI	himin.	hd 21215	-
	Sta	ite	31. Date filed (Month, Day, Year)	3 Registrar's Signar					,1 0 0	~ ~ 1 - 1]	-
	Registr	-	MAY 0 5 2008		1998						
DH	MH 17 Rev 1/2	001		6.00	_ _						

DHMH 17 Rev 1/2001

Shirley 100 with

	_	1 - State of Maryland / Departr	cate of Death	ental Hygien	ZIIII 1 15/3/			
Physicia /Medica Examine	n al er	Maryland General Hospital I	City, Town, or Location of Death	ty	Year Year Year Ac. County of Death 9. Birthplace (State or Foreign			
Funeral Director		260-54-0420 1MM 2□F 69 Yrs. Mo Usual Residence of Decedent		Date of Birth (Month, Day, Yea 5-9-193	36 GA			
e Marylan	Director	MD 10a. State 10b. County 10c. City, Town or Location BALTIMORE			10d. Inside City Limit 1 🖔 Yes 2 🗆 No			
urs after death v	by Funeral	1703 BENTALOU STREET 11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	of. Zip Code 21216 Decedent of Hispanic Origin? (Speci, specify Cuban, Mexican, Puerto Ri		USA 14. Race - American Indian, Black, White, etc. Specify: BLACK			
d within 72 jene. r than "na ina Madic	Be Completed	(Specify only highest grade completed) (Give kind life. DO N	Usual Occupation of work done during most of working OT use retired) IANCE WORKER 18. Mother's Name (I) First, Middle, Maide				
s 1 and 2 should be filed the file and Mental Hyg item 27 le marked othe other traumatic event,	20		dress (Street and Number or Rural I					
rages 1 and ment of Healt lant: If item 2: lury or other (20a. Method of Disposition 1 Burial 2 Commation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremator METRO CREM	(Name of py or other place) IATORY 5-6-2	20c.	Location - City or Town, State			
Departing Department of the control					FON & SONS F.H., INC ORE, MARYLAND 2121			
ysicie	ical Examiner	stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CREPTOVASCULO. Due to (or as a consequence of): Due to (or as a consequence of): CREPTOVASCULO.	pholopathy eumonia 2 Accident	4	Interval Between Onset and Death 4 Ady			
e attending pl	Physician/Med		pic pregnancy er (specify)		23d. Date of delivery Month Day Year			
e de d	2	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of death?			
- 2	Completed			24a. Was an autopsy performed/	24b. Were autopsy findings available prior to completion of cause of death?			
After this certilitioneral director	10 26	25. Was case referred to medical examiner? 1	28c. Injury at 28 Work?					
r Attention ter deal	Certification:	2 Sweets 6 Could not be	of Injury - At home, farm, street, factory, office 28f. Location (Street City or Town, St.					
within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ and and manner stated.	urred at the time, date and place, an ation, in my opinion, death occurred	d due to the cause(at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)			
within within	W	29b. Signature and title of certifier 30. Name an address of person who comple use of death (Item 23a) (Type, Print)	29c. License number 89536 Maryland		Date signed (Month, Day, Year) 5/4/06			
State Registra		31. Date filed (Month, Day, Year) MAY 0 5 2006 Registrar's Signature	Marey land	C OTENE	eral Hespetal			

			1 = For State Registrar	State of M	laryland	•	artmen rtificat			ind M		giene leg No.) 6	14233
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	Day 2	Year Year	3. Time of Death
1	/Medic Examin	-	4a. Facility Name (If not institution, g	ive street and number	·)		4b. City,	Town, or	Location o	f Death			ity of Death	1
	_ Xuiiiii		Riderwood Renai	ssance Gar	dens	1	Si	i1ver	Spr	ing		Mon	ntgom	ery
	Funeral			Sex 7. A 1 M 2 T F	ge (In yrs. la 83	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign intry)
	Director		082-14-1776 Usual Residence of Decedent			113.					02-14-	-1923	Net	w York, NY
	ryland thow	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	8a-f	ecto		gomery	S	ilver								1½∏vyes 2∏No
	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f ehow he Madical Examiner must be notified at	Funeral Director	3124 Gracefield	Rd.			10f. Zip	Code	20904	4		10g. Citizen o US		intry?
	death	nera	11. Marital Status	12. Was Deceden	Ever in U.S	S. 13.	Was Deced	dent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		ace - Amen	
98	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯 If Yes, Give	No		1 ☐ Yes		Specify:	, Fuerto i	Ticali, etc./		lack, White, city: Wh:	
ë	tural'	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a. Dece	dent's Usua	al Occupa	tion			16b. Kind of	Rusiness/Ir	ndustry
215	hin 72 In "ne Marik	Completed	(Specify only highest of Elementary/Secondary (0-12)		5+)	(Give life.	kind of wor DO NOT us	rk done d se retired)	uring most	of workir	ng			•
2	ed wit ygiene ner tha	Con		4		Adn	inist							Service
and	should be fill and Mental Himarked ott	To Be	17. Father's Name (First, Middle, La. Simon Lester Tr								(First, Middle, an Soko:		ame)	
Maryland 21215-0036	nd 2 shou Ith and M 27 is mar traumat		19a. Informant's Name/Relationship Nancy Love/daug								Route Number			p Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f ehow eny fulury or other traumatic event, the Macical Examination at 2000.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	□ Removal from State	re	ace of Dispo emetery, crer	sition (Nan	ne of ther place)	D	ate	20c. Location	- City or T	own, State
ij			4 □ Donation 5 □ Other (Spec	cify)	Che	sapeal					04-2006	Be1	tsvil	le, MD
Bal	Depar Impor		21. Signature of Funeral Service Lic) Im	01358		933 (Fune Gist	ral &	& Cre	emation er Spri	ng MD		
2	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that cause ty one cause on each	od the death. line.	Ni	er the mod	p	1			est,		Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions.	b	AAW	X11								
1/	cuted nd ransit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequ	ence of):								
8760,<	ate be executed hysicien and the burial-transit	cai Ex	resulting in death) Last	Due to (or as	s a consequ	ence of);								
9	artificat ing phy e as th	Medi	IF FEMALE:					-						
O. Box	law requires that the death certificase been signed by the attending pl 2 should be detached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr Other (sp			-			ate of deliv Month	ery Day Year
rds, P.O.	puires that I n signed by uld be deta	ρ	Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying c	ause give	n in Part I.		23e. Did to	1		the cause of death?
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ion of	Attending Physician: r death. ector: After this certific: by the funeral director,	ation:	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inj (Month, Date)	ury ay Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	_ -	2	8d. Describe h			//
Division	al or Atte s efter de: ol Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place of in	njury - At hor tc. (Specify)	me, farm, str	eet, factory	, office		2	t8f. Location (S City or Town	treet and Nun n, State)	nber or Rur	al Route Number,
	To the Hospital or Attending Ph within 24 hours alider death. To the Funerel Director: Alter th completely filled in by the funeral	edicai (29a. Certifier (Check only one) 1 Certifying I	Physician: To the bes aminer: On the basis and manner s	of examinati	vledge, death ion and/or in	occurred vestigation,	at the time, in my op	e, date and inion, deat	place, a	and due to the c ad at the time, d	ause(s) and nate and place	manner as s a, and due t	stated. to the cause(s)
	To the vithin 2 To the complet	¥	29b. Signature and title of certifier	1. A 1.	\			. License			2	9d. Date sign	ed (Month,	Day, Year)
			- Txulay /4	CHAT W)			0043	3379	5		5/3/	06	
	ľU				cacefi	eld Ro	d. Si	lver	Spri	ng M	D 20904	• /		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2	006 Regist	rar's Signati	ure do	de la							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U U Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death MAY 2006 Year **Physician** 1 MELVIN LIPINSKI 6:15 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner McFAUL ROAD BALTIMORE RASPEBURG If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-21-1919 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □MM 2 □ F 86 Yrs 217-09-4079 Director MARYLAND Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County ?7 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD BALTIMORE RASPEBURG 1 Yes 2 XNo Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code with 5126 McFAUL ROAD 21206 U.S.A. death Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic even." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ X/es 2 ☐ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specity: Specify: WHITE þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER BALTIMORE CITY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LIPINSKI PETER MARGARET (O'HARA) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD LIPINSKI/SON 5126 McFAUL ROAD BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 5-5-2006 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVENUE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARKINSON'S DIS GARE **Physician** /Medical Due to (or as a consequence of) Examiner OLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 0 THY RUDISM 1 Yes 2 No 3 Probably 4 Unknown Completed peen RESSION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 | No 1 ☐ Yes 2 ☐ No 1 Yes : After this certifice funeral director, I or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 15 Residence 6 Other (Specify) 1 Yes A No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 11 Natural 5 ☐ Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funeral Dire 4 T Homicide To the Hospital 29a. Certifier Vertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 48025 Must arm 3 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, BATA ND 21237 ARMI MIS 1224 22. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 5 2006 Registrar

		For State Registrar	State		/land / De		t of H	lealth a	and M	lental Hyg		nna	14235
		Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath		3. Time of Death
Physici /Medio		ANNA	MOTE	N						Month 5/3	/20	06 Yeer	11:00a
Examir		4a. Facility Name (If not institution 9000 Briar	n, give street and	number)		4b. City,		r Location urel	of Death		40	County of Dear	Georges
Funeral Director		5. Social Security Number 065-22-3165	6. Sex 1 ☐ M 2/3 /	7. Age (II	n yrs. last birthd 82 Yrs	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 4/3/1	v, Year)	9. Bird	thplace (State or Foreign ountry) VA
PL .		Usual Residence of Decedent		146	oc. City. Town o	1							
shov ed at	ក	MD Prin	ce Geor			rel							10d. Inside City Limits 1 ☐ Yes 2 ☑ Ng
tha M	rect	10e. Street and Number	ce deoi	ges	лас		Code				10a. Cît	tizen of What Co	ountry?
Idd yiddiid Z IZ ID-DODO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28e-f show reumalic event, the Madical Examiner must be natified at	Funeral Director	9000 Briar Cro	ft Lane	Apt	305			708				US.	A
r daat ams	ner	11. Marital Status		ecedent Eve Forces?	r in U.S.	3. Was Dece If Yes, spe	dent of H	lispanic Or an, Mexical	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3XXVidowed 4 ☐ Divorced	If Yes,	Give TDates:		1 Tes		Specify:				Specify:	Black
s hour	ed b		it's Education	or Dates:	16a. De	cedent's Usu	al Occup	ation			16b. K	ind of Business	· · · · · · · · · · · · · · · · · · ·
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in yie thould id Mer marke marke	T ₀	19a. Informant's Name/Relations			19b. M	ailing Address	(Street			al Route Numbe		or Town. State.	Zip Code)
INICA nd 2 s lith an 27 is rtrau	N 8	Harold Drummor	1 1 21 1	iew	1001111	-				Severn			_,, 0 0 0 0 0 0
portilition of the property of the control of the permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation				rematory or	other plac			Date		ocation - City or	
Deartified Department of important: If it any injury or o		* 4 □ Donation 5 □ Other (S		ctor						/8/2006			VA
Depariment of the policy of th		21. Signature of Funaral Service 23a. Part 1. Enter the disease, o shock, or heart failure. List		>	Doda	Charl	es l	L. Si	teve	ns Fur	mor	el Homo	21230
DIVID		23a. Part1. Enter the disease, o	r complications th	at caused the	death. Do not	enter the mo	le of dyin	ng, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		FM	PHYSE	MA							Onset and Death
/Medical Examiner		resulting in death)	Due		onsequence of):								101,11
Zammer	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due	to (or as a co	onsequence of):								
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<	,									
be exacuted be exacuted cian and burial-transit	Exa	resulting in death) Last	Due Due	to (or as a co	onsequence of):								
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eath cer attendir for use	cian/	23b. Was decedent pregnant in the past 12 months?	1 Liv		Fetal death	3 ∐Ectopic p 5 ∐ Other (s		/				23d. Date of de Month	livery Day Year
the day the ached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown		nknown	0 01 00011								
s that	by PI	Part II. Other significant conditi		o death but n	ot resulting in th	e underlying	ause giv	en in Part	1.	23e. Did to	bacco	use contribute to	o the cause of death?
w requires been signishould be	led	HYPERTE	121011							X	es 2	□No 3□P	robably 4 Unknown
law re law re las be	ompieted									24a. Was autop	sy	prior to	utopsy findings available completion of cause of
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ding Physician: h, After this certific funeral director,	5	1 ☐ Yes 2 No 27. Manner of Death		Inpatient ate of Injury	2 ER/Outpa		28c. Injur	4 🗆 141	ursing Ho	ome 5 Resid		6 ☐Other (Spe	ecify)
ding th. :: Afte	atior	Natural 5 Pendi	ng (A	Month, Day Yo	ea <i>r)</i> Inju	у м	Wor 1 □	k? Yes 2□] No				
Attence of death rector:	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 289. Pl	ace of Injury uilding, etc. (- At home, farm	street, factor	y, office			28f. Location (S City or Tow			ural Route Number,
ital or ral Die	Cer		1										
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai		ng Physician: To Examiner: On th and n		amination and/o								
To th withir To th comp	Me	29b. Signature and title of certific	72-		4.7	29		e number	-			ite signed (Moni	
		•	1100	-, r	ND		DE	567	97	-	MF	143,	2006
5		30. Name and address of person 13952 BALT	who completed of	AVE	h (Item 23a) (Ty	oe, Print) UREL	LAL	TAR	HA	TADI	30 2K	707	, M.D.
Sta Regist		31. Date filed (Month, Day, Year MAY 0		2. Registrar's	Signature	A 11	_						
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			1 - For State of M	laryland / Depa	artment of Hertificate of L	Death	Reg.	Z U U 5	14236
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Lavern	Mai	nzur		2. Date of Death Month AU	Day ZVear	3. Time of Death G 4.33 AM
	Examin		4a. Facility Name (If not institution, give street and number Genesis Health Care		4b. City, Town, or Balt:	imore	J	4c. County of Deat	
	Funeral Director		5. Social Security Number 220–64–5160 Usual Residence of Decedent	ge (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 6-26-56	9. Birt Co	hplace (State or Foreign untry) Md.
	Maryland -f ehow	tor	10a. State 10b. County Md. NA	10c. City, Town or Lo	cation timore				10d. Inside City Limits 1 X Yes 2 □ No
	with the	Direc	10e. Street and Number 4711 Navarro Avenue		10f. Zip Code 212	15	10g.	Citizen of What Co	untry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23s or 28s-f show eny injury or other treumatic event, the Medical Examiner must be notified an once.	by Funeral Director	11. Marital Status 12. Was Deceden Armed Forces 11. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes 24. If Yes, Give	No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	I within 72 horiene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 12th grade 2 Yrs	5+)	dent's Usual Occupa kind of work done d DO NOT use retired)			Ero Proje	_
and ;	d be filed antal Hyg cad othe c event,	To Be C	17. Father's Name (First, Middle, Last) Leverne	Apson		18. Mother's Name Roa	(First, Middle, Mai		
Maryland	12 shoul h and Me 7 is mark treumati	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address <i>(Street</i> a				Zip Code)
Baltimore, I	Pages 1 and hent of Healt int: If Itam 2 iry or other i		Yvette Johnson Si 20a. Method of Disposition 1 During Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispo	osition (Name of matory or other place	Da	ate 200	: Location - City or Randallsto	_
Balti	permit. Departrimporta Importa eny inju		21. Signature of Ameral Service Licensee	2;	Name and Address March F.		Baltimore 1101 E	e, Md. 2 E. North	1202 Ave.
760,	by Course as the burial-transit for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of):	AIDS	, such as cardiac of	тозрівкої у втозі,		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of del Month	ivery Day Year
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Division	To the Hospitel or Attending I within 24 hours after death.) To the Funeral Director: After completely filled in by the funer	Certification:	27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of In (Month, D	njury - At home, larm, stetc. (Specify)	M 1□Y	res 2 □No	28f. Location (Stree City or Town, S	et and Number or Ri	ural Route Number,
	ne Hospit	edical (29a. Certifier (Check only one) Certifying Physician: To the besi Amedical Examiner: On the basis and manner of the control o	of examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a sinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To the comp	×	29b. Signature and title of certifier X 1 Clo Cloud. 30. Name and address of person who completed cause of CO UM 5 CO	nd, y ph	29c. License	D576	42 /	Date signed (Mont	th, Day, Year) 206
	0		30. Name and address of person who completed cause of		RUIN	Blue 3	13 Ba	Ot. mro	2/239
	Sta Registr		31. Date filed (Month, Day, Year) 32. Degis MAY 0 5 2006	trar's Signature	isole)				

06-02944 Please Type or Print in Black Indelible Ink Celestine Mason State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death egistrar Reg. No 1 Decedent's Name (First Middle Last) Physician/ 2. Date of Death Month Day May 1, 2006 Medical Examiner 1530 hrs 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 3020 Walbrook Avenue Apt. 3 Baltimore 5. Social Security Numbe **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days Director Months Hours Min Foreign M Country) Usual Residence of Decedent 10b County 10c. City, Town or Location 10d Inside City Limits 23a or 28a-f show n tified at nee. X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e Street and Number 10g. Citizen of What Country or items 23a Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 White, etc. 2 X No Yes Yes, Give Year Widowed Divorced Yes 2 X No specify is marked other than "natural", atic event, the Medical Examiner Specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be a 19a. Informant's Name/ elationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 20a Method of Disposition 20b. Place of Disposition (Name of cemetery X Burial crematory or other place) 2 Cremation Important: injury or oth 200 Donation 5 Other Specify gnature of Funeral Service Licenses 22. Name and Address of Eac 110. **Physician** ens that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Approximate Interval lure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page this certificate Yes 2 **V** 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene 1 🗸 Yes 2 ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 No the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. **Medical** 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ق 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 2, 2006 Name and address of person who completed cause of death (Item 23a) Theodore King MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

			For State Registrar	State of	Mar	yland /		artmen tificate			and M	lental Hy	giene		1:238
			1. Decedent's Name (First, Middle, Las	t)								2. Date of De Month	ath Da	y Year	3. Time of Death
	Physicia /Medic		Lillie Mae Mark	.s										2006	9:30 P M
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			Shady Grove Advent			ta1 In yrs. last	hirthday	Roc]	kvil	le If Under	24 Hrs	8. Date of Bir		ontgome	Ty thplace (State or Foreign
	Funeral Director		236-80-3428	7 M 2 X7 E	91	iii yis. iasi	Yrs.	Months	Days	Hours	Min.	May 5,	191	4 Wes	t Virginia
			Usual Residence of Decedent												· · · · · · · · · · · · · · · · · · ·
	urylan show	_ ا	10a. State 10b. County		1	Oc. City, T	own or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	Ba-1	Director	Maryland Montgome	ry] I)erwo	od	104 7:-	0-4-				10- Ci	tizen of What C	
	with t a or 2 ben	吉	10e. Street and Number 7361 Oskaloosa Dr	ino				10f. Zip	0855					S.A.	ountry:
	leath ms 23	Funeral	11. Marital Status	12 Was Dece	dent Ev	er in U.S.	13.)			spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Am	
9	or Iter	逼	1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes If Yes, Give	2 📉 No			fYes, spec 1 ☐ Yes :				Rican, etc.)		Black, Wh	
8	ours a	d by	3 X Widowed 4 □ Divorced	Year or Da	tes:	1								Specify: Wh	
<u>7</u>	"nati	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		1	(Give	dent's Usua kind of wor DO NOT us	k done o	<i>lurina</i> mos	t of work	ing	16b. K	(ind of Busines	s/Industry
2	withir lene. than	Completed	Elementary/Secondary (0-12)	College (1	4or 5+)		Homer			,			0,	wn Home	
Ď Ž	offiled Hyg other	Be C	17. Father's Name (First, Middle, Last)			,				18. Mothe	er's Name	e (First, Middle	Maider	Sumame)	
/lar	uld be Menta Nrked ritic ev	To B	Hiram Carter							A1	lice	Rudd			
ar	and l		19a. Informant's Name/Relationship (7		_			-						or Town, State,	Zip Code)
<u>ک</u>	l and tealth im 27 her tr		Carolyn Abbott /I	augnter				USKa.		a Dr.		rwood,		∠USDD .ocation - City o	r Town State
Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow important: If time 7 is marked other than "natural", or Items 23a or 28a-f ehow eny Injury or other treumatic event, the Mactical Examinar count the notified at once.		1 XBurial 2 ☐ Cremation 3 ☐		State	Tyfe	Y MO	ncan	ther plac	θ) 1	5-6-				
들	artmer artmer ortant Injury		4 □ Denation 5 □ Other (Specify 21. Sign ture of Funeral Service Licen			Memo	22	arden: 2. Name an	d Addres	s of Facilit	tv		Cna	rleston	, WV
Ba	Depa Impo eny I		2 lenni /2	11/1/1	4		į	Kelle:	r Fu:	neral S Ave	Hon	unbar,	WV	25064	
		П	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that ca	aused th	e death. I									Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		<	FP	515	7							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ice of):)	-						1 Diy
П	LXAIIIIICI	J.	Sequentially list conditions,	b	C/ 85 8 /	consequen	ne effe								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	20001											
Č	execu in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	consequen	ice of):								
8760,	cate be executed physicien and the burial-transit	Icai		d											
	ing ph	Med	IF FEMALE:	22 1/	Transition.										
Вох	eath certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 2 months?		irth 2	pregnancy Fetal de ne of deat	ath 3	Ectopic pr						23d. Date of di Month	elivery Day Year
P.O.	by the a	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unkno		ne or dear	n 5	J Ottrei (sp	ocny)			-97			
۳.	The law requires that the death certific sie has been signed by the attending p age 2 should be detached for use as:	by Ph	Part II. Other significant conditions of	ontributing to de	ath but	not resultir	ng in the u	nderlying c	ause give	en in Part I	l.	23e. Did t	obacco	use contribute	to the cause of death?
rds	w requires been sign should be											10	Yes 2	ENo 3□F	Probably 4 Unknown
Vital Records,	e law requ has been je 2 shouli	Completed										24a. Was	an psv	24b. Were a	autopsy findings available completion of cause of
	w	Com										perfo 1 ☐ Yes	2 N	death?	
/ita	iclan: T certificet rector, pa	Be	25. Was case referred to medical examiner?	Hospitali					Oth		e of Deat	h (Check only o	one)		
ð	ding Physician: h. After this certific funeral director,	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital:	npatient		VOutpatier 3b. Time o			4 🗆 140	ursing Ho	me 5 Resi		6 Other (Sp	ecify)
o o	After	tion	Natural 5 Pending 2 Accident investigation	(Mont	h, Day	rear)	Injury	м	8c. Injun Worl 1 □	k? Yes 2□	No	200. 20001120		.,	
Division of	or Attending ter death. Irector: After In by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place	of Injury	y - At home	e, farm, str	reet, factory	, office			28f. Location (City or To			Rural Route Number,
á	s afte et Dire	Certification:	4 Hornicide	Dulidir	1g, etc.	(Specify)						City or 10	wii, Otal		
	To the Hospital or Atte within 24 hours after de To the Funeret Directo completely filled in by th	edicai	29a. Certifier 1 Certifying Ph (Check only one)		asis of e	xamination									
	To the To the Comp	Ž	29b. Signature and title of certifier	71.	<u></u> i			290		number	12			ate signed (Moi	
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	5		30. Name and address of person who	cal Ce	nt	2	Dri	Print)	Ro	dkv	ille	MD	2	0850	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 5 20	06	egistrar	s Signatur	e de la constante de la consta	Select of the se							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per the 8855 5-30-06 Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) April 29, Year 16:09 P.M Physician Belle V. Moton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital Center 4b. City, Town, or Location of Death Examiner Prince George's Clinton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth Month, Qay, Year, September 27, 1917 Social Security N**7642** 577–22–**7646** 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🖾 F Maryland Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County , or Iteme 23a or 28a-f show the Medical Examiner must be notified at Suitland 1X Yes 2 □ No Prince George's Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20746 3508 Silver Park Drive Apt. #1 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Printing Office Book BInder permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: if item 27 is marked other the any injury or other traumatic event, Lagone. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3508 Silver Park Drive Apt. #1 Suitland, Maryland 20746 19a. Informant's Name/Relationship (Type, Print)
Mary E. Moton (Laughter) 20c. Location - City or Town, State Brentwood, Maryland 20b. Place of Disposition (Name of Date 20a. Method of Disposition Fort Lincoln (enetery May 6, 2006 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rollins Fueral line, Inc. 21. Si nature of Funeral Service Licenses 4339 Hunt Place, N.E. Washington, D.C. of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAMIAE ARRYTHM A
o (or as a consequence of): **Physician** /Medical Examiner ntern Ocheose ougu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 QUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes To the Hospitel or Attending Phyelcian: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 DOA 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D41580 5-1-00 \geq

DHMH 17 Rev 1/200

State Registrar 7503 Surratts Road Clinton, Maryland 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Scott Kelso, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Mc. Good Mantha 11:30 AM 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayview Hospital Baltimore City Johns Hopkins If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month. Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗷 F 47 Yrs 214-78-1231 Director Marvland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "naturel", or items 23s or 28s-f shov the Medical Examiner must be notified at 1 XYes 2 ☐ No Funeral Director Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 USA 2236 Essex Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 MDivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ò Truck Driver Trucking . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 is marked other to jury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adrian J. Taylor Jean M. Marcontonio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard McCloud, Jr./ 3824 2nd Street Baltimore, Md. 21225 Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery | 5/8/06 Baltimore, Md. 21. Signature of Funeral Service Licensee Kaczorowski factiuneral Home P.A. 1201 Dundalk Ave. Baltimore, Md. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intravascular Coaquilation Disseminated Hours /Medical Due to (or as a consequence of): Examiner Fulminant Hepatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physiclen and use as the burial-transit Attending Physician: The law requires that the death certificate be executed Alcohol Vears Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Year Month Day signed by the et d be detached fo 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Tes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral is 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

RES-060

Emily Sydnor, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Manyland 21287

May 3, 2006

Medical Doctor

32 Strar's Signature

Emly Lyolis

MAY 0 5 2006

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1243 PM **Physician** Year Norton **IENN** 2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) ware Hospita Ba timore Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2 □ F 219-34-1702 Yrs. 0 Director Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MARKVIll Director mo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8725 AVE USA permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e any injury or other traumatic event, the Medical Expenses once. VONDACE 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Harried 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) SALTIMURE Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VORTON LEROY 2 UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 8725 AUE EVELYN AVONDACE PARKUILLE NURTON -MO 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date DIANEL VALLEY
MENGRIAL GARDENS 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 IMONIUM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 HARFORD RD. YARKUITE, MD 21234 FUNERAL 23a. Part1. Enter the disease, or complications that caus 11th e death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à effer death. I Director: Affer this certificete has been signed t d in by the funeral director, page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 ☐ Yes 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manher of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral D completely filled 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) ္မ 05

DHMH 17 Rev 1/2001

State

Registrar

Name and

dress of person wha con

2006

leted cause of death (Item 23a) (Type, Print)

32. Aegistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Year Ellsworth Mason April 30, 3:30 p /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartord Memoria Hospita Havre de Grace Under 1 Year | If Under 24 Hrs. Harford 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 1, 191 **Funeral** Birthplace (State or Foreign Country) Months Days Hours Director 212-07-8299 Yrs 86 Maryland 1919 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or iteme 23s or 28e-1 show other traumatic event. The Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Mulberry Lane 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify Specify: 3 ♥ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h end Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant 4 Mattress Distributor Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages t end 2 should be nent of Heelth end Mental Howard Mason Orem Edna ည May Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages t end 2: Department of Heelth er Important: if item 27 is eny injury or other traugone. Dennis D. Orem - Son 36304 Brittinghem Road, Delmar, Delaware 19940 ce of Disposition (Name of Date 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 5/05/06 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Cussell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) teriosclerotic cardiovascular disease ettending physicien and for use as the burial-transit Physician/Medical Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year ed by the e 5 Other (specify) P.0. 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Completed 1 ☐ Yes 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Vital 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 Unpatient 2 EP/Outpatient 3□ DOA o After thi 27. Manner of Death Medical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the hours efter deat uneral Diractor: 6 ☐ Could not be determined 3 Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) *1 completed cause of death (Item 23a) (Type, Print) 10

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State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 2006 .Iohn Edward Oleksik 3:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 503 48th Street Baltimore Eastwood If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 219**-**10-6262 Sept20,1927 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic evant, the Mudical Examiner must be notified at Md. 1 ☐ Yes 2 ☑ No Baltiore Eastwood Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 503 48th Street 21224 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ty∏yes 2 ∏ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married permit. Pages 1 and 2 should be filled within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or any injury or other traumatic event, tra Mulcal Examinance. 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8th Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oleksik Pauline Ramiszewski John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Oleksik (wife) 503 48th Street Baltimore, Md 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory May4,2006 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Records,

Hospital or Attending Physician:

Division

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After

within 24 hours after death

To the Funaral Diractor:
completely filled in by the

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, or Itams 23a

Baltimore, Maryland 21215-0036

Be Completed Certification: To

Medical

examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5. sidence 6 ☐ Other (Specify) 1 🗌 Yes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year) 27. Manner of Teath 5 Pending investigation

28b. Time of Injury

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

4 | Homicide

3 🗌 Suicide

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

29d. Date signed (Month, Day, Year) 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Bay see Ctr, Baltum 4D 20124

Registrar

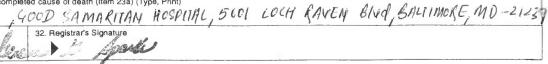
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Manyland Department of Health and Montal Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3 Time of Death Year **Physician** 7.53 PM 29 04 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution on, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL SAMARITAN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F Days Hours Yrs orth woling Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Mcdical Examination must be notified at 1XYes 2 No MD Funeral Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15A Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Blac Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
file. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) filed within 7 Hygiene. and Mental Hygiene. College (1-4or 5+) ses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Durighter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relations (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tret once. 20a. Method of Disposition Date 20c. Location City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -6-06 Name and Address of scility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Si SEP **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PERIPPERAL VASCULAR 1 Yes 2 No 3 Probably € Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No STAGE 24a Was an REMAL DISESE HYPERTENSION FINE MIA certificate DISEASE 28/110 1 LI Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospita. ... within 24 hours after death.
To the Funerel Director: Altra-lately filled in by the fur 1 Natural Injury 5 Pending 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 State Registrar

NIVEDITA PANDEY 31. Date filed (Month, Day, Year) MAY 0 5 2006

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

RES-000

04-29-2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death May 2, 2006 Year **Physician** Diane Evelyn Pargament 8:26 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 2011 Bank Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/03/1941 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 65 216-38-2820 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No N/A Baltimore Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 2011 Bank Street United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) Housing Manager other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James William McDairmant Jr. E. Katherine Mead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Scheitlin - Stepdaughter 1706 Rittenhouse Avenue Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or permit. Page Department of Important: if any injury or once. Cemetery

22. Name and Address of Facility

David J. Weber Funeral Homes P.A.

401 S. Chester Street Baltimore, Maryland 21231

Approximate Interval edween

Approximate Interval edween

Company Such as cardiac or respiratory arrest. Timonium, Maryland 21. Signature of Funeral Service Licensee Do not enter the mode of dying, such as cardiac or respiratory arrest.

ONEAST CARCINOMA 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign , page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 ☐ Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death Check only examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ၉ 1 🗌 Yes 27. Manne Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 **atural** 5 Pending 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	state of Marylan		rtment of t			iene 2006	14247
			Decedent's Name (First, Middle, Last)		-			2. Date of Deat	h	3. Time of Death
	Physici /Medio		Rolert F Peterson Sr.					Month	Day 2006	4:00 AM
	Examir		4a. Facility Name (If not institution, give stre	et and number)	. 1	4b. City, Town, o	or Location of Deat	th/ (4c. County of Deatl	10-00
			5. Social Security Number 6. Sex	7. Age (In vrs.	()	If Under 1 Year	If Under 24 Hrs	1 P Para at Black	BOUT	MONE
H	Funeral Director			2□ F 84	last birthday) Yrs.	Months Days			Year) 9'. Birth	nplace (State or Foreign untry) 1th, MN
	פ	١.	Usual Residence of Decedent					Julie 24 J	.,21	
	anylan show	٠.	10a. State 10b. County		y, Town or Loc	ation				10d. Inside City Limits
	Ba-f	Director	Maryland Baltimore	Dall	imore	T				1 ☐ Yes 2 ☐ No
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	ns 23	Funeral	11. Marital Status 12.	Was Decedent Ever in U.	.S. 13. W	as Decedent of I	Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer	
٥	or ite			Armed Forces? 1 XYes 2 No		Yes, specify Cub ☐ Yes 2KKNo	an, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
21215-0036	hours after tural', or ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		Tes ZAMO	Specify:		Specify: Wh	ite
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7	filed within 72 Hygiane. hther than "nated, it a Medici	m d m	Elementary/Secondary (0-12)	College (1-4or 5+) NA		esident of	-/		Manufacturing	Tridustry
ğ	be filed within 72 hours after death with the Marylan ital Hygliene. id other than "natural", or Items 23a or 28a-f show event, I'ra Medical Examinar must be notilited at	Be C	17. Father's Name (First, Middle, Last)				1	me (First, Middle, A		5
<u>a</u>	T - T /	To B	Abel Peterson				Clara Pie	ring		
Maryland			19a. Informant's Name/Relationship (Type,	Print)					City or Town, State, Z	ïp Code)
	and 2 Health om 27 i		Mary Schaefer 20a. Method of Disposition	20h P	801 Ha		t East Be	l Air, Mary	Land 21014 20c. Location - City or 1	Four Ctate
٥	Pages nent of h int: If Ite		1 ☐xBurial 2 ☐ Cremation 3 ☐ Rem	oval from State	emetery, crem	atory or other pla	1			
Baitimore,		55	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Gar		Name and Addre	. May ¦5 200 ess of Facility	ю Е	Baltimore, Man	ryland
ñ	permit. Departr Importe any inj		Matta Amonto	Joseph			eral Home I	_	1 01006	
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock.	ions that caused the death	n. Do not ente	Ol Belair	Road Balti ng, such as cardia	nore Mary I c or respiratory arre	and 21236	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Bacton			monie	A C		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		hine		-		
	É	<u>-</u>	Sequentially list conditions, b	Due to (or as a conseq	uence of):					
	uted 1 Innsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		2000 0.,.					
ລົ	be executed sicien and burial-transit		that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):					
79/R	the death certificate be executed y the attending physicien and Iched for use as the burial-transit	dlcal	d							
٥	artifica ing pt e as t	(a)	IF FEMALE:							
X Q Q	eath certific attending p	lan/	in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3 ☐	Ectopic pregnanc	у		23d. Date of deliments	very Day Year
oj.	the de	iyslo	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify) _				
7.	w requires that the de been signed by the should be detached	by Physician/M	Part II. Other significant conditions contrib	outing to death but not res	ulting in the un	derlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	requires that een signed b hould be deta	ed b	Cerebral V	ascular	2;	soase		1 □ Ye	s 2⊠No 3⊟Pro	obably 4 Unknown
ပ္သ	law re as bee 2 sho	plet						24a. Was ar	24b. Were aut	topsy findings available ompletion of cause of
r	The law ate has b page 2 sl	Completed						perform 1 ☐ Yes 2	ned? death? ☑No 1 ☐ Yes	2 □ No
VITA	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	nital:		Ott	206	ath (Check only one		
5	ding Phys. h. After this c funeral dir	2	1 165 2 100	1 Lefinpatient 2 L	ER/Outpatient 28b. Time of	3LI DOM		Home 5 ☐ Resider	nce 6 Other (Spec	ify)
0	th: : Afte	tlor	1 ☐ ¶atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2 □No		,,	
DIVISION	or Attendent eller deatl	Certification:	2 Cuiside 6 Could not be	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Number or Ru	ral Route Number,
5	ital or rs efte al Dir led in	Cerl		ounding, etc. (Special)	·/			Ony or roun	, State)	
	To the Hospital or Attending Physician: within 24 hours eller death To the Funeral Director. After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physicia (Check only 2 Medical Examiner:	an: To the best of my kno On the basis of examina	wiedge, death tion and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death occi	e, and due to the ca urred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the vithin 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
}	- s - ŏ		Da m	11 =2		Dr.	w/ L			
1.	f d		30. Name and address of person who comp	leted cause of death (Item	23a) (Type, P	Print) Anne		٠	may 1,	7606
Ø	.01		9800 waltho	1 Boole					1234	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	Les of				
			BANV B 5 AUUU	E30 100 00 1 100	120					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 6:30P. **Physician** icher enneth MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Aiv Kos ARFORN Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 83 Months Days Hours Min Yrs. 218-14-2 Director DALTIMORE, MD Usual Residence of Decedent 10c. City, Town or Location 10b County 10d. Inside City Limits 10a. State 28e-f shov treumatic event, the Medical Examiner must be notified at 1 Yes 2 XNo Be Completed by Funeral Director HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pernit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural! or item any injury or other treumatic event USA 1605 2101 Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1/4or 5+) Elementary/Secondary (0-12) roving Ground naineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ser Her Der 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1605 2101 MO 20a. Method of Disrosition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evanstruneral Chapel-Belthir 5-4-06 Forest Hill 22. Name and Aldress of Facility Forest Hill MD 21050 -21. Signature of Funeral Service Licensee 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. 3 Newport Dr Approximate Interval Between Onset and Death Immediate Cause (Final 10 4/1 ARTERY DISCASE ORONA Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be execut Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ icate has been signated by page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner 1 1 Matural 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hc To the Fun completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and endew 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Belay MD21014 S. NAIRM. JAY. 60 1) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 5 2006 Registrar

		ľ	1 - For State Registrar		aryland / De		Health and I	Mental Hygi	•	14249
	Physici		Decedent's Name (First, Middle, Last)	Arc	dell Rode	n		2. Date of Death Month	Day Year 2006	3. Time of Death 12:00 а м
)	/Medio Examir		4a. Facility Name (If not institution, give s				or Location of Death		4c. County of Death	more
	Funeral Director		214-84-4/23	7. Ag	e (In yrs. last birthda 45 Yrs.	y) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Jan 17,	9. Birth Cou	place (State or Foreign ntry) Vlaryland
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/	A	10c. City, Town or		Baltimore			10d. Inside City Limits 1 → Yes 2 → No
	3a or 28	i Direc	10e. Street and Number 123 West 29th Street			10f. Zip Code	21218	10	g. Citizen of What Cou U.S.	-
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show says injury or other traumatic event, Ira Musical Exactlical minal ke incilliad at ance.	by Funeral Director	11. Marital Status 1☐Mever Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Siban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify:	
Maryland 21215-0036	I within 72 housens.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Gi		upation e during most of wor ed) se Assistant	king	6b. Kind of Business/Ir	
land	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Ronald	Roden	'		18. Mother's Nan	ne (First, Middle, M Evely)	aiden Sumame) n Barksdale	
	and 2 sho alth and 1 27 is ma or trauma		19a. Informant's Name/Relationship (Type Evelyn Barksdale Mothe	•	19b. Ma	-			City or Town, State, Zi e, Maryland 212	
Baltimore,	Pages 1 ament of He ant: If Iten ury or oth		20a. Method of Disposition 1	emoval from State	cemetery, c	position (Name of rematory or other pi etro Cremator	1	05/05/06	Oc. Location - City or T	
Balt	permit. Depertiumport. eny Inj		21. Sign rule of Funeral Service Lizens	, 836	8P.SC	22. Name and Add Estep 1300	ress of Facility Brothers Fund Eutaw Place B	eral Service, F Saltimore, Md	P. A. 21217	
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	COLON	CANCER	enter the mode of dy	ring, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
7,092	Examiler and special and see the purish-transit see the purish-transit see the purish and	icai Examiner	Sequentially list conditions, It any Lating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):					
P.O. Box 68	The law requires that the death certifica Ite has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of deliv Month	ery Day Year
	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause g	even in Part I.		acco use contribute to l	
al Reco	: The law re cate has be page 2 sho	Completed						24a. Was an autopsy perform 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2□ No
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ition; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Inj	ther: 4 \(\text{Nursing H}	ome 5 Resider 28d. Describe how	nce 6 X Other (<i>Speci</i>	(v) HOSPICE
Divisi	Mospital or Attending 24 hours after death. • Funeral Director: After etely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, c. (Specify)	street, factory, office	9	28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier Check only one) Certifying Phys	sician: To the best ner: On the basis o and manner st	of my knowledge, de f examination and/or ated.	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the car rred at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
•	To th within To th comp	Me	29b. Signature and title of certifier)		29c. Licer	1372	29	d. Date signed (Month,	,
	2		30. Name and address of person who co		leath (Item 23a) (Typ		TIMONIUM,	MD 2109	3	
	Sta Regista		31. Date filed (Month, Day, Year) MAY 0.5.20	32. Registr	ar's Signature	book	-			

MAY 2, 2006 12:00 a.m.

ARDELL RODEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend item 29d, per doc 2855 5-4-06 vt
State of Maryland (Department of Health and Mental Hygiene

				State of Maryland	•	tificate of			Reg. No. 2	NA	11.250
	Physicia	n	1. Decedent's Name (First, Middle, Lest)		D.0	TUDI COM		2. Date of Dee Month MAY 1,		Year	3. Time of Death
	/Medic	al -	BARBARA 4e Fecility Name (If not institution, give st	reet and number)	RU	THBLOOM	4b. City, Town, or L			of Death	8:05 PM
- Alle	Examin	er	KESWICK NURSING H				BALTIMO			7.5	N/A
	Funeral Director		5. Social Security Number 6. Sex 220-48-9903	7. Age (In yrs. le	est birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 12/14	7932	9. Birthpl Count	lace (State or Foreign try) MD
	wo the	1	Usuel Residence of Decedent 10a. State 10b. County	10c. City	Town or Loc	ation				10	0d. Inside City Limits
	Mery	į	MD BALTIMO	RE	BALTI	MORE					1 ☐ Yes 2 ☐ No
	ith the	Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of W	/hat Count	
	eath w	erai	6608 AMLEIGH ROAD	Was Decedent Ever in U.S	13. W	/as Decedent of H	21209	pecify Yes or No-	14. Race	e - America	USA an Indien,
21215-0020			11. Maritel Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U,S Armed Forces? 1		Yes, specify Cub ☐ Yes 2 💢 No	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	k, White, e	
5-0	72 ho	eted	15. Decedent's Educa (Specify only highest grede	ation completed)	16a. Decede	ent's Usual Occup	oation during most of word d)	king	16b. Kind of Bu	siness/Ind	lustry
212	within then then then then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)			CHNICIAN		HOSPIT	AL	
br	e filed al Hygi other vent,	Be C	17. Father's Neme (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumam	e)	
Maryland		ဥ	BENJAMIN			ISTEIN	SARAH		o: **		SILVERMAN
Mai	d2 thar trat	1	19a. Informent's Name/Relationship (Typ LISA SINGER / DAU	GHTER			ROAD - B.				Code)
re,	of Heali Itam 2 other	1	20a. Method of Disposition	20b. Pla		ition (Name of atory or other pla		Date	20c. Location -		wn, State
imo	nit. Pege entment c ortant: If injury or		1 M Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)				AL PARK				OWN, MD
Baltimore,	permit. Peges 1 e Depertment of He important: If Item any injury or othe price.		21. Signature of Funeral Service Liberges.	atten		Name and Addr. 900 REIS	STERSTOWN	OL LEVIN ROAD -			
	100		23a. Part1. Enter the diseese, or complice shock, or heart failure. List only one	ations that caused the death. cause on each line.	Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory are	rest,	1	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final	5' -0	27.2	5 6 7 . 4	10000				1.4.10
	Examiner		disease or condition resulting in deeth) a.	Due to (or	as e consequ	JYM	Crerra				75
7	ait sit	iner	b.								
ν -`	ificete be executed g physician end es the buriel-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or	as a consequ	uence of):				İ	
68760,	yslcia yslcia	edicai	Cause (Disease or injury that initiated events resulting in death) Lest	Due to (or	as a consequ	ence of):					
	entifice ling ph		d.							1	
Вох	leath certifi attending d for use es	cian						ont Dida		4.11. 4. 4.	the cause of death?
P.O.	the c by the achex	Physician/M	Part II. Other significent conditions conti	4.4	Iting in the un	derlying cause giv	ven in Part I.	236. Dig t	8		the cause of death?
	w requires that been signed I should be det	by P		ellitus, A	77	10 4,61	rillation	1			
Records,	requir	Completed by	multiple str	okes, con	gest	ve her	art	24a. Was a perfor		ava	ere autopsy findings allable prior to appletion of cause
Rec	e law has b ge 2 s	id III	6 0		,			1 D Y	es 2 No		déath? ∃Yes 2□ No
Vita		Be C	25. Was case referred to medical				26. Place of Dea	th (Check only of			168 20 70
of Vi	Physician: r this certific rel director,	일	examiner? 1 ☐ Yes 2 No		R/Outpatient	3LI DOA		ome 5 Resid			<i>'</i>)
	Ing Pl		27. Menner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo M 1		28d. Describe h	low injury occurr	ed	
Division	Attending or deeth.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	ne, farm, stre		,		Street and Number	er or Rure	l Route Number,
ō	s efter	Cert	4 Homicide	building, etc. (Specify,				City or Tow	m, State)		
	To the Hospital or Attending Phys within 24 hours effer deeth. To the Funeral Director: After this completely filled in by the funeral d	edical Certification:		cien: To the best of my know er: On the basis of exeminati and manner stated.							
	Nithin (or the comple	Ž	29b. Signature and title of certifier			29c. Licens			29d. Data Yie	i (Month, i	Day, Year)
	->-0		I Al Anthu	filey "	m	00.	5005		April	2,	2006
	6		30. Name and address of person who con	npleted cause of death (Item	23e) (Type, F	Print)	5205 Encles St.	est Prol	to ind	2:2	عره!
	9	0	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure / ((14.00		2000			
	Stat Registra		MAY 0 5 20	06	4 6	2. 1. 2					

			. For	State of Maryla	nd / Depa	artment of	Health and		•	11.251
,			State Registrar		Ce	rtificate of	Death		Reg. No.	19601
ı	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last	RITTER				2. Date of Dea	02 200	6.4.05 AM
	Examin		4a. Facility Name (If not institution, give				or Location of De	eath !	4c. Cbunty of D	
			Northwest Hospita 5. Social Security Number 6. Se		s. last birthday)	Randal If Under 1 Year		Hrs. 8. Date of Birt	h o	Birthplace (State or Foreign
	Funeral Director			^{2 M 2□F} 66		Months Days	Hours M	April 2	7, 1940	Maryland
	land ow		10a. State 10b. County	10c. 0	City, Town or Lo	ocation		·		10d. Inside City Limits
	a-fsh iffied	tor	Maryland Baltimor	e	Randa11	stown				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
	ath w	ra	9109 Liberty Road			21133	115	VC===#. V====N=	U.S.A.	American Indian,
	Item Item	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2XXNo		77		(Specify Yes or No- uerto Rican, etc.)	Black, V	White, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel', or Items 23a or 28a-f show amy injury or other traumatic event, Ite Mariel Examination and be notified at once.	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕮 No	Specify:		Specify: V	
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7	within ene.	duic	Elementary/Secondary (0-12) Unknown	College (1-4or 5+)		tenance	50)		Mobile Ho	me Park
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ylan	Menta Menta arked atic ev	To B	Unknown		known		Elsie			Unknown
Jan	2 sho and Is ma		19a. Informant's Name/Relationship (T		11	CH THIS			er, City or Town, Stai	te, Zip Code)
	1 and Health em 27 ther t		Margarette Fequie 20a. Method of Disposition		. Place of Dispo	York Ro osition (Name of matory or other pi	ad. Balt	imore, Ma	ryland 2 20c. Location - City	1212 or Town, State
no	ages int of t: If It		1. A varial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State		matory or other pi of Faith		7 5 2006	Baltimor	o MD
Baltimore,	nit. Partme		21. Signature of Funeral Service Licens				ress of Facility M	Miller-Dip	pel Funer	al Home, Inc.
m	Depar Depar Impo any ir		Vessin	Huzz					re, Maryl	
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only	lications that caused me de	eath. Do not en	ter the mode of dy	ring, such as care	diac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
E	Physician	(II	Immediate Cause (Final disease or condition resulting in death)	a	4EUM	nun				Onset and Death
E	/Medical Examiner			Due to (or as a cons		504.5	**************************************		211017111	
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cons	editerios al).	ECENO	11.2	io De	CUBITYS	
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· END	STAGI	E REN	IAL C	DISEASE	- '	
760,	te be executed ysician and e burial-transit	cal Ex	resulting in coats) Last	Due to (or as a cons	equence or):					
687	icate physics the			d						
Box (n certii Inding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		Testania necessar			23d. Date of	delivery
Ö.	The law requires that the death certiticate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		⊒Ectopic pregnan ⊒ Other (s <i>pecify)</i>			Month	Day Year
P.O.	hat the	Phy	9 Unknown Part II, Other significant conditions co	ontributing to death but not i	resulting in the L	underfying cause o	uven in Part I.	23e. Did t	obacco use contribut	te to the cause of death?
Vital Records,	w requires that been signed to should be deta	Completed by	~	MELLI	-			10	Yes 2□No 3□	Probably 4 Unknown
00	w req	lete	ANEN	·				24a. Was	an 24b. Wer	e autopsy findings available
Re	The law	mo	1111						ormed? deat	
Ita		Be C	25. Was case referred to medical examiner?					Death (Check only o	_/1	
	Physician: this certitic ral director,	2	1 ☐ Yes 2 📉 No		☐ ER/Outpatie	III JUDON			dence 6 Other (Specify)
ono	ding F h. After tunera	tlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	ork? □Yes 2□No	28d. Describe	how injury occurred	
Division of	r Attending er death. rector: After by the tune	Certification:	3 Suicide 6 Could not be determined		t home, farm, st ecify)	reet, factory, offic	ө	28f. Location (: City or Tox		r Rural Route Number,
Ö	Hospitel or the hours afte Funerel Dir tely filled in tely filled in the hours of t									
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the tuneral	edical		ysician: To the best of my k niner: On the basis of exam and manner stated.						
	To the within To the complete	Me	29b. Signature and title of certifier	0 20 01-	N		nse number		29d. Date signed (N	
)	1) oggindn	r medi	M.T		4141		may ozh	12006.
	31		30. Name and address of person who			Print) Joen	MOER	6 WEH	TA	00
		ate	31. Date filed (Month, Day, Year)	No SOTTINGEN	gnature	Min	SALLS	rown	mo 211	35 /
	Regist		MAY 0 5 200	12. Registrar's Sig	S. Apple	NEW YORK				

			State of Maryland / D		nt of Health a re of Death	nd Mental	Eng E	06	11.252
		State Registrar Decedent's Name (First, Middle, Last)	1.4//	Jeruncai	e ui Dealii	2. Date (A . J.	3. Time of Death
Physic /Medi		Charles 3	STATON	4		M3	~ 4	- 06	// AM
Exami	ner	4a. Escility Name (If not institution, give st	(ChAPA	45. City	DO To Location of	NOPE	4c. (County of Death	
Funeral	21.41.41	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under	r 1 Year If Under 2 Days Hours		of Birth	9. Birth	place (State of Foreign
Director		Usual Residence of Decedent				1-	<u> </u>	2 101	MUZIINI
tarylan ehow	-io	10a. state 10b. County	10c. City, Town	or Location	/A				10d. Inside City Limits 1 ☐ Yes 2 No
h the M r 28a-f	Irect	109-Street and Number	Ma Daire	10f. Zi	Code		10g. Citiz	en of What Gou	intry?
death with the Maryland ma 23a or 28a-f ehow	Funeral Director	4314 TUNEA	2. Was Decedent Ever in U.S.	13 Was Dece	0 /0 G	in? (Specify Yes	or No-	4. Race - Ameri	ican Indian.
after de or Item	Fun	11. Marital Status 1 Never Married 2 Marned 1	Armod Forces? Yes 2 No If Yes, Give	If Yes, spe	dent of Hispanic Orig ecify Cuban, Mexican, Specify:	, Puerto Rican, etc		Black, White Specify:	
D-UUSO 72 hours at naturel', or dical Exam	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	Decedent's Usu	al Occupation		16b, K in	of Business/Ir	ndustry
CIA ithin 72 ne ne	Completed	(Specify only highest grade	Collegi (1 Arr 5+)	(Give, kind of w life, IDO NOT I	ork done during most	of working	3	200	
filed within Hygiene. other then '	Be Cor	17 (Father's Name (First, Middle, Last)	10-14	HEST	18/Mother	r's Name (First, N	iddle, Maiden	Surpamp)	1-0
should be nd Mental marked o	To B	WILLS Stat	ON		HNX	JIE 14	HE	StOK	ES monto
Baltimore, Maryiand ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Itema 23a or 28a-1 show any injury or other traumatic event, tra Medical Examinational tenrutified at once.		19a Informant's Name/RelationeHip (Typ	i)(Cousiv) 9	319	s (Streetjafid Numbe)	DRW	EMA	Town, State, Zi	(NU)
nore, ages 1 a not of Hez nt: If item y or othe		20a. Method of Disposition Burial 2 □ Cremation 3 □ Re	cemeter	Disposition (Na , crematory or	me of other (*c=)	Date 5-/	20c. Loc	ation - City or J	dwn, State
Baltimor permit. Pages Department of timportant: If it temportant: If it on the final of the first of the fir		4 □ Donation 5 □ Other (Specify) 21. Sign(1) re of Funeral Service License	1 THEOL	22/Name a	nd Address of Facility	J096V	THE G	DOCK	S. M. J. Him
Department on the contract of		Cinthu 7.	Balmo	13021	U. CENTE	ALAVE.	PAIL	O. NO	200
		23a. Part1. Iter the disease, or complic shock, it heart failure. List only on tmmediate Cause (Final	ations that caused the death. Do no cause on each line.	ot enter the mo	de of dying, such as o	cardiac or respirat	ory arrest,		Approximate Interval Between Inset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of	41 [4712 ii):	- NOSTE	ie a			unpreser
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68/ trificate trificate as the	Aedical	IF FEMALE:							
I HECORGS, P.O. BOX 6 The law requires that the death certific see has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐Ectopic 5 ☐ Other (s			2	3d. Date of delik Month	very Day Year
T.O.	hysic	1 Yes 2 No 9 Unknown	9□ Unknown						
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aw request should	Completed		Diubetes			24a.	Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
The i						1 🗆 🖰	performed? Yes 2 No	death?	2 No
VIC Sician certifi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Out	toatient 3 7	Other	of Death (Check rsing Home 5		Other (Spec	uhr)
Division of Vital Records, for Attending Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be to	on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. T	ime of	28c, Injury at Work?	28d. Des	cribe how injury		ny)
ISIO Nttendi death. ctor: A y the fu	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fail building, etc. (Specify)	rm, street, facto	1 Yes 2 1	28f. Loca	tion (Street and	d Number or Ru	ral Route Number,
Div	Certification:	4 Homicide	building, etc. (Specify)			City	or Town, State)	!	
LIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1// Certifying Physical Check only one)	ician: To the best of my knowledge ler: On the basis of examination and and manner stated.	, death occurre d/or investigation	d at the time, date and n, in my opinion, deat	d place, and due t th occurred at the	o the cause(s) time, date and	and manner as place, and due	stated. to the cause(s)
To the within To the	Me	29b. Signature and title of certifier		2	9c. License number	<i>(</i> :		e signed (Month	
.\.		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type Print\	12756	9	5	13/06	
		30. Name and address of person who co	Hettlewer	, ype, Fillit)	838 (Greene	Tree	Rel	21208
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Sink !	,		•		

			For State Registrar	State of I	Maryland	l / Depa	artmeni rtificate	t of He e of D	ealth ai Death	nd Me		gien Reg. N		11.25	3
1			1. Decedent's Name (First, Middle, Las	1)				-		2	Date of De		. V-	3. Time of De	ath
	Physici /Medic		Oren Herbert Sa	anders						P	Month April :		2006 Yes	6:40	РМ
	Examin		4a. Facility Name (If not institution, give		er)		4b. City,	Town, or 1	Location of				c. County of D		
		N. 94	706 Chesapeake Dr	rive			Ste	vens	ville			1	Oueen A	nno!c	
	Funeral	-	5. Social Security Number 6. Se	9x 7.	Age (In yrs. ia	st birthday)	If Under	1 Year	If Under 2		Date of Birt (Month, Da	th	9.1	Birthplace (State or Fo	oreign
200	Director		523-28-1901	∑ M 2□F	78	Yrs.	Months	Days	Hours	Min.			1928 Cc	country)	
	D.		Usual Residence of Decedent												
	ehow	_	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City L	
	Sa-f	cto	Maryland Queen A	nne		Steve	nsvil	le						1 □ Yes 2	KINO
	or 28a-f	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What	Country?	
	after death w or items 23s	rai	706 Chesapeake Dr	ive				2166					nited S		
	en e	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S es?	. 13.	Was Deced	lent of His	spanic Origin, Mexican,	in? (Speci Puerto Ri	fy Yes or No can, etc.)	-	14. Race - A Black, W	merican Indian, hite, etc.	
36	or it	by Ft	1 Never Married 2 Married	1√∑Yes 2 If Yes, Give			1 □ Yes 2		Specify:					White	
5-0036	72 hours after death with the Maryland inetural, or Items 23e or 28e-f ehow dical Examinar must be notified at		3 ☐ Widowed 4 ☐ Divorced	Year or Date	s: WWII										
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2121	within then.	E	Elementary/Secondary (0-12)	College (1-4	or 5+)							_			
	Hygie Hygie Sthar		17. Father's Name (First, Middle, Last)		1	Comm	unica			's Name (First, Middle,		relepho	ne	
au	should be filed within 72 hours nd Mental Hygiene. marked othar then "netural; matic event, tre Modical Exa	Be	_	J											
Z	d Me mark matic	은	Joel Oscar W. Sand			19h Maili	na Address	(Street a			Pearl		eed or Town, State	Zio Codol	
Maryland	" = m 3												,	, , = ,	
_	Heal Heal Heal ther		D. Glenn Sanders, 20a. Method of Disposition	Son	20b. Pla	22 S.	Jeff	ersol	n Str	eet _{bat}	Freder	cicl	c, MD 2	1701 or Town, State	
יסנ	or o		1 ☐ Burial 2 ☐ Cremation 3 ☐		ate Ce/	петегу, сте	matory or o	tner place	7						
altimore	ntmer rtant		4 Donation 5 Other (Specify		West	Arunde				4/25/2			entan, Me		
Bal	permit. Pages 1 end 2 Department of Health a important: if item 27 is any injury or other tre ange.		21. Signature of Funera Service Licen:	300			2. Name an			Har				vice, P.A.	,
AA.	and the Control		23a. Part1. Enter the digease, or comp		M01113								nie, M	D_21061	
			shock, or heart failure. List only of	one cause on eac	h line.	Do not en	or the mod	e or aying	, such as c	ardiac or r	espiratory a	rrest,		Approximate Interval Betwee Onset and Dea	en eth
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pro	ostate	Cance	r							185	
	/Medical Examiner		1	Due to (or	as a conseque	ence of):									
My.		<u>.</u>	Sequentially list conditions,	b. Due to (or	as a conseque	ance of):									
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D09 (0 (0)	as a conseque	SIIC 6 01/.									
	and and Il-trar	xan	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):									
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87		dicai		d											
9 x	death certific e attending p id for use as i	/Me	IF FEMALE:	23c. If yes, outcome	me of pregnan	CV							004 D (4-2	
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<u>α</u>	requires that the de een signed by the a nould be detached t		Part II. Other significant conditions of	ontributing to deat	h but not result	ting in the u	nderiving c	ause give	n in Part I		23e. Did t	obacco	use contribut	to the cause of deat	th?
Records,	sign d be	1 by	THE SECTION STATES				, , , ,							Probably 4 □Unk	
Ö	w requir been si should	Completed								_			21		
ec	S S S	du									24a. Was autor	osy	24b. Were prior	autopsy findings ava	ulable se of
=	Thate page	Co									1 ☐ Yes	rmed?			
Vital	Physician: The lands this certificate harmal director, page	Be	25. Was case referred to medical examiner?	11				101		of Death (Check only o	опө)			
)	Physi this c	은	T Tes ZIXINO	Hospital: 1 ☐ Inp		R/Outpatie			4 🗀 1401				6 □Other (S	pecify)	
Division of	Ing P	Certification:	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time o Injury		8c. Injury Work			d. Describe I	how inj	ury occurred		
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				М		′es 2 □ N						
Ξ	or At ifter d Direct in by	TT.	4 Homicide determined	289. Place of	Injury - At hon , etc. (Specify)	ne, farm, st	reet, factory	, office		28	f. Location (City or To	Street a wn, Sta	and Number oi ite)	Rural Route Number	r.
	To the Hospital or Attending I within 24 hours after death. To the Funarel Director: After completely filled in by the funer														
	Hospital 14 hours a Funarei (Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	riner: On the basi	s of examination	rledge, deat on and/or in	h occurred vestigation.	at the tim, in my op	e, date and inion, death	l place, an	d due to the l at the time,	cause((s) and manner nd place, and	as stated. due to the cause(s)	
	To the within 2 To the complet	Med	one)	and manner	r stated.			. License							
	5 1 1 5 0	1	29b. Signature and title of certifier.					_						onth, Day, Year)	
	1		Zum Dan	mm			-	413	27			Ma	y 5, 200	6	
- 1	7 '		30. Name and address of person who o												
i.	A C A		31. Date filed (Month, Day, Year)	13	30 Love pistrar's Signatu	Poin	Road	l, Su	uite 1	07,	Steven	svi	lle, M	21666	
	Sta Registi		MAY 0 5 %	All .	notiar o olyriati	10 A	. 10	-							

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death 0051 110 2000a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Maryland Cox Daltimore, Ma Under 1 Year | If Under 24 Hrs. Baltone Maryland Universit HOSPITAL Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 1 ☐ M 2 🛣 F Months Days Hours 216-20-3262 83 2-05-23 N.J. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State Yes 2 □ No Baltimore Md. 10e. Street and Number NA 10f. Zip Code 10g. Citizen of What Country? USA 21216 2342 Riggs Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: 3 √Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FEGT Clerk 12th grade 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matthews Charles Unkn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1939 Mosher Street, Baltimore, Md. Harold Conway Godson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, Md. 5-8-06 Arbutus Mem. PK. 21. Signature of Funeral Service Licensee 21202 22. Name and Address of Facility Baltimore, Md. la 1101 E. North Ave. March F.H. East Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final angurys 3 aun til disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 menths? Month Day Year 4 Pregnant at time of death 5 Cther (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, the Hospital

use as the burial-transit attending physician and for use as the burial-tran ed by the a signed by page 2 should be certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

traumatic event, the Medical Examiner next by notified at

other 1

Department of H Important: If ite any injury or ot once.

Physician

Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

2

with the Maryland

Examiner Physician/Medical Certification: To Medical

Be Completed by

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State

Registra

2006 5

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MD

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

DHMH 17 Rev 1/2001

		-	For State Registrar	St	ate of	Marylan	d / Depa <i>Cei</i>	artmen tificate			ind M		Reg. No.	UUU		4255	
	Physicia		Decedent's Name (First, Middle									2. Date of D Month	eath Day	2006 ^{Ye}	ar	3. Time of Death	
	/Medic Examin	al	Rose Mar 4a. Facility Name (II not institution 322 Oberle	n, give street	and numl					Location o	f Death	May		County of D Balti	eath	/2:52AM	
	Funeral Director		5. Social Security Number 214-20-9035	6. Sex		. Age (In yrs.	last birthday) O Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of B	irth Day, Year)	9.1925 ^{9.1}	Birthplac Auntry	ce (State or Foreign	_
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore			ry, Town or Lo	eation				-	•		100	I. Inside City Limits	_
	or 286	Jrec	10e. Street and Number	_				10f. Zip					10g. Cit	izen of What	Country	/?	
	ath w	rai	322 Oberle				0 101	_	1221		-:-2 (0	adu Vaa ar h	USA	14. Race - A	morioan	Indian	_
980	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow ta Medical Exanding must be notified at	l by Funerai Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorces	nied 1	/as Deced med Ford □Yes 2 Yes, Give ear or Dat	P. No		was Deced If Yes, spec		Specify:	, Puerto	ecify Yes or N Rican, etc.)		Black, W Specify: V	Vhite, et∉ Vhit	te	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12th		n npleted) oll eg e (1-	4or 5+)	16a. Deced (Give life. Sec	dent's Usua kind of woi DO NOT us reta	rk done a se retired	ation <i>Juring m</i> ost)	of worki	ng	Reg		01	stry f Wills County	
Maryland 2	uld be filed Jental Hyg rked other	To Be C	17. Father's Name (First, Middle, William H.		hins					_		(First, Midd . War		Sumame)			
, Mary	alth and N		19a. Informant's Name/Relation Mary Sacilo			hter		•				al Route Num 11timo			тө, <i>Zip</i> С 2122		
Baltimore,	Pages 1 and of the total of the		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (val from S		Place of Dispo cemetery, crei K Lawi	matoni or o	ther place	ry 5		0 6		cation - City . timo:			
Balti	permit Departn Imports any inju		21. Signature of Funeral Services	Licensee	0	nnel		2. Name an				00 Ma 1 Hom	ce A	ve.Ba	alto	o.MD 21221	
	Physician /Medical Examiner		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complication to fally one ca	Due to (c	LD M or as a consec LD Co	yuence of): JA	ter the mod	le of dying	g, such as Bein AR	oardiac () The Des	n respiratory	arrest,		2	Approximate niterval Between Onset and Death	
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c d	·	or as a consec											
.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Live bi	ome of pregn th 2 ☐ Feta ant at time of a	aldeath 3	□Ectopic pi □ Other (sp					-	23d. Date of Month		r Day Year	
Δ.	Se Co	þ	Part II. Other significant condit	ions contribu	iting to de	ath but not re	sulting in the u	underlying o	ause givi	en in Part I			d tobacco			cause of death?	
Il Records,	The law ate has b page 2 si	Completed										pe	as an topsy rformed?	prior	to com	sy findings available pletion of cause of	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	al Hosp	tal:				Oth	00		h Check on!					-
of	ding h. After fune	ıtlon; To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pend 2 ☐ Accident inves	2	Ba. Date o		28b. Time of Injury		28c. Injun Worl	4 🔲 140		ome 5 Ae 28d. Describ			Specify)		
Division		Certification;	3 ☐ Suicide 6 ☐ Could	not be 2	8e. Place buildin	of Injury - At I	nome, farm, st	reet, factor	y, office				(Street a. Town, State		or Rural	Route Number,	
	To the Hospital or within 24 hours after To the Funeral Direction of th	edicai		l Examiner:		sis of examin	owledge, dea ation and/or in	rvestigation	n, in my o	pinion, dea			e, date an	d place, and	due to t	the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certif	er					_	e number	, /		t	ate signed (N		ay, Year)	
,	1001		30. Name and address of perso			of death (Ite	om 23a) (Type	, Print)	121	122	<i>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </i>	10 21	17	5.4.	00	336	
40	1	0.4	31. Date filed (Month, Day, Yea		32. Ba	ン ogistrar's Sign	rature	170	0 15	10 4/	-	10 21	12	/			
	St Regist	ate rar	MAY 0		17.8	alues.	N A	posts	Ç.								

				State of Maryla				-		HOEC
			For State Registrar			rtificate of I			eg. No.	14200
65	Physici		Decedent's Name (First, Middle)	, Last) 0//				2. Date of Dea		3. Time of Death
	/Medi		Cuelyn	N. Smith.					03 2006	5:40 PM
9	Examir	ner	4a. Facility Name (If not institution			BEL F	Location of Death		4c. County of Death	0
Te Te	Funeral		5. Social Security Number		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)	HARFO 9. Birth	place (State or Foreign
	Director		218-07-0513	1 □ M 2 12 F	86 Yrs.	Months Days	Hours Min.	11-12	-1919 mA	RYLAND
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Many a-f sh	ţ	MD HAR	FORD	1:	Bel Air	-			1 ☐ Yes 2 No
	or 28s	Direc	10e. Street and Number	01 0		10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	uus atter death with the Marylar el', or Items 23a or 28a-f show Examiner must be notified at	Funeral Director	404 Marteli	Ct. 6	10 10	21	014.		USA	on India
10	r Item	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No			ispanic Origin? (Spann, Mexican, Puerto	Pican, etc.)	14. Race - Ameri Black, White	
215-0036		b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: W	hite.
200	"natu	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dece	dent's Usuaf Occupi kind of work done o	ation du <i>ring</i> most of worki	ing	16b. Kind of Business/Ir	ndustry
212	filed withir Hygiene. Sthar than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Sec	retary	'	1	Forest Hill	PANIC
	be filed stal Hyg id other	BeC	17. Father's Name (First, Middle,	Last)		a credity	18. Mother's Name			01,10,0
) ja	should be nd Mental marked c	To	Charlest	· Morris			Flora	Wat	45	
Maryland	C) @ = @		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	A Route Number	r, City or Town, State, Zi	Code)
	s 1 end f Health tem 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	11 (1., 1	Date	20c. Location · City or T	own, State
E E	Pages nent of int: If It		1 Burial 2 Cremation 4 Donation 5 Other (S _k	3 Li Removal from State	COMPLETY, CIET	to cost VA	Com 5-8	-06 1	macisan.	40
Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 any injury or other tr		21. Signature of Funeral Service	icensee	22	. Name and Addres	s of Facility	ropes	THILLI	NP 21652
ш	20519	17 7	Kinceley	. Sololly	E E	ANS FUR	eral Cho	pel 3	Newport	DR.
			shock, or heart failure. List	complications that caused the dea only one cause or each line.					est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. CEREBRO1 Due to (or as a conse		LLAR	ACCIDE	NT		
	Examiner		Sequentially fist conditions	b						
	bed isit	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a conse	quan ce of).					
	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
760,	0 0	cai		d.						
89	Attending Physician: The law requires that the deeth certifical refath. r death. sctor: After this certiticate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Medi	IF FEMALE:							
Вох	eth cer attendin tor use	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	afdeath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
P.O.	t the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	death 5	Other (specify)				
ď.	res that igned b	by Pi		ns contributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	bacco use contribute to t	he cause of death?
ord	w require been sig	ted	HYPERTENSI					1 🗆 Ye	as 2□No 3□Prol	pably 4 Unknown
ec	has by	nple	HYPOTHYRO	DISM	-			24a. Was a autops perform	n 24b. Were auto by prior to co death?	psy findings available impletion of cause of
a	ician: The l certiticete ha		25. Was case referred to medical				00 Et / D	1 ☐ Yes	No 1 ☐ Yes	2 No
Ξ	ysician: is certific director,	To Be	examiner?	Hospitaf: 1 ☐ Inpatient 2 ☐] ER/Outpatien	t 3 DOA Othe	26. Place of Death er: 4 X Nursing Ho		eel ance 6 □Other (Speci	(v)
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 ★Naturaf 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		ow injury occurred	
isio	death. death. ctor: A y the fu	icati	2 Accident investig	ation			Yes 2 No	286 1 (Cr	and and Market and O	
Div	after of Direction by	Certification:	4 ☐ Homicide determi	ned 28e. Place of Injury - At h building, etc. (Speci	ify)	eet, factory, office		City or Towr	reet and Number or Rur. n, State)	al Houle Number,
	To the Hospitel or Attent within 24 hours after death within 24 hours after death To the Funerel Director: completely tilled in by the		29a. Certifier 1 Certifying (Check only 2 Medical I	g Physician: To the best of my kn	owledge, deatl	occurred at the time	ne, date and place,	and due to the ca	ause(s) and manner as s	itated.
	the H in 24 the F nplete	Medical	One)	examiner: On the basis of examinand manner stated.						
	D IN OR	2	29b. Signature and title of certifier	a day		29c. License	number	2	9d. Date signed (Month,	Day, Year)
P	101		30. Name and address of person	who/completed cause of death (Ite	m 23a) (Tune	Print)	5544		05/04/2	UNE
1-	U			ANJANI, MD.	225	UNION	AVE, HAV	IRE DE G	FRACE, MD.	21078
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Sant o	7.		9d. Date signed (Month, 05/04/2 GRACE, M.D.	
	Registi	ar	MAT (J. J. Loud Jakonera	13.	CANADASO P				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Robert Earl Sanders **Physician** 6:15 P. M 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gwyn Oak Augsburg Lutheran Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 → F **Funeral** 192-07-0676 94 July 19, 1911 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, Inc. Medical Exart must be notified. 1 Yes 2 No Baltimore County Maryland Gwyn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Campfield Road Apt. 8 F 21207 United States Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Alcoa Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Matilda Heil William Sanders 19a. Informant's Name/Relationship (Type, Print)
Richard Babcock (Son-In-Law) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Dee Jay Drive Elicott City Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition May 5,2006 permit. Pages Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral Cremation Ctr. P.A. 2325 York Road Timonium Maryland 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastv **Physician** weck /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 AND 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy 20 No 1 Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 🔼 🛱 o 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3,7006 1737773 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Mari 21136 22 St C. 1201 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 2006 Registrar MAY 0 DHMH 17 Rev 1/2001

Physician/

Medical Examiner

Richard Carroll Smith, Sr.

			e Type o												
h, Sr.	St	ate of Maryla	and / Dep	partmer	nt of	Health	and	Menta	al Hy	giene		()	ni	1	14:258
1- For State			Ce	ertificat	e of	Death					Reg	No.			1 11 600
Registrar 1. Decedent's Name	e (First, Midd	le,Last)								2. Date of					3. Time of Death
RICHA	ARD CA	ARROLL S	MITH,	SR						Month April 30), 20 0		Year		0000 hrs
4a. Facility Name (i	f not institution	on, give street and no	ımber)	_	4	b. City, Tov	vn, or L	ocation of	Death			4c. Co	unty of	Death	
Greater Bal	timore Me	dical Center				Towson	1					Balti	imore	Cou	nty
Social Security N	lumber	6. Sex	7. Age (In yrs	. last birthda	ay)	If Under	1 Year	If Under:		8. Date o	f Birth(N	MM/DD/			hplace (State or
213-26-	-5354	1 X M 5 2 F	75	5	Yrs.	Months	Days	Hours	Min.	July	7 12	2,19	930	Cou	n untry) Maryland
Usual Residence of															
10a. State	10b. County		10c. Ci	ty, Town or	Location	on									10d. Inside City Limits
MD	В	altimore	2	1	Parkville										1 Yes 2 X No
10e. Street and Nu	mber					10f. Zip Co	ode	_	10g. Citizen of What Country?					ntry?	
8303 Ha	arris	Avenue				2	123	4					U	SA	
11. Marital Status 1 Never Marrie	ed 2 VM	12. Was De arried Armed F	cedent Ever in orces?	U.S. 1		s Decedent es, specify (Race - White,		can Indian, Black,
1 1 Yes 2 No											Wh-	ite			
3 Widowed 4 Divorced of Pates:										Spe	ecify:	,,			
15. Decedent's Ed	ducation (Spe	cify only highest gra	de completed)			t's Usual Oc					16	b. Kind	of Bus	iness/Ir	ndustry
Elementary/Seco	ondary (0-12)	College (1-4 or 5+)	- aur	_	ost of workin			e retir	eu)	Ġe	ener	al I	Mot	ors Assembly
9															
17. Father's Name	Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)														

Funeral Director 213-26-535 Usual Residence of Deceder 10a State 10b Cou any or items 23a or 28a-f show must be notified at once. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 8303 Harri Funeral 1 Never Married 2 Widowed "natural". Ş 15. Decedent's Education (Completed Elementary/Secondary (0 9 is marked other 17, Father's Name (First, Mid Albaugh Louise Roy James Smith 8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8303 Harris Avenue-Parkville, Maryland 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is injury or other traumati Evelyn Gladys Smith-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 5-5-06 Rossville, Maryland Donation 5 Other Specify 21 Sanature of Funeral Service Licensee 22. Name and Address of Facility EVANS Road-8800 Harford failure. List only one cause on each line

Physician

Baltimore, MD 21215-0036

/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Finneral Director: After this certificate has been signed by the attending nhysician and

Division of Vital Records, P.O. Box 68760,

...ing physician and use as the bire /sician/Medical

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Completed

Be

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Between Onset and Death Pulmonary Thromboembolism Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Left leg deep venous thrombosis Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) X UNPENDED AMENDED item#23a-b,27,perME,g856,6/1/06 TT 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown

				autopsy performed?	prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26.Place of Death (Chec	k only one)	
examiner? 1 ✓ Yes 2 No	oital: 1 🗸 Inpatient 2	ER/Outpatient 3	DOA Other Nur	sing Home 5 Residence	ce 6 Other:
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d Describe how injury	occurred
1 X Natural 5 Pending	(Month, Day,Year)		1 Yes 2 No		
2 Accident Investigation	OD: Diservatible Addr			206	All makes as Burnel Bauta Alumbas C

ဥ	1 ✓ Yes 2 No	i W inpatient 2	ENOutpatient 3	DOA 4 Nulsi	ng home 5 Kesiderice 6 Other.
ion:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d Describe how injury occurred
ertificat	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At he	ome, farm, street, factor	y, office building, etc.	28f. Location (Street and Number or Rural Route Nu or Town, State)
edical C	one) 2 Medical Examiner:		-		d due to the cause(s) and manner as started. at the time, date and place, and due to the cause(s)
š	29b Signature and title of certifier		2	9c. License number	29d. Date signed (Month, Day, Yea.

30. Name and address of person who completed cause of death (Item 23a)

Theodore King MD. 31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

May 2, 2006

State Registra

Assistant Medical Examiner 32. Registrar's Signature

06-02905		Please Type or Print in Black Indelible Ink			
Rebecca Jeanne		Appendix Amend Item #4a Per ME G857.17/03/06 JH Registrar Amend Item #5.8.10e&18 Per ME G856 6/27/06 JH	giene Rec 2. Date of Death	g No.	11,25
Physicia Medical Exami	1117	REBECCA J. SCHROLL	Month April 30, 20		3. Time of Death 0530 hrs
		41. Facility Name (if not institution, give street and number) 711 Christinson, Arce Way #B 4b. City, Town, or Location of Death Edgewood		4c. County of Deal	h
Funeral Director		5. Social Security Number 212-02-4044 7. Age (In yrs. last birthday)	8. Date of Birth	1 ;965 Fore	ountry
Š.		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location	170730	703	10d Inside City Limits
nd how any ce.	L	mo Harford Eogewood			1 Yes 2 No
farylar 28a-f s	Director	107 Firest and Number Crimson Tree Way	10	g. Citizen of What Co	untry?
with the Maryland ns 23a or 28a-f sh pe notified at once		THE CRIMSON WAY APT. 15 21040		USA	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Forces)		14. Race - Ame White, etc.	rican Indian, Black,
ifter de	by Fu	1 Yes 2 No 1 Yes 2 No specify: or Dates:		Specify: W	HITE
72 hours after death n "natural", or iten al Examiner must		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life, DO NOT use retire		16b. Kind of Business	
136 thin 72 te than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker		RESIDE	NCE
ore, MD 21215-0036 s. I and 2 should be filed within 72 hours after death with th of Health and Mental Hygiene If item 27 is marked other than "natural", or items 23a ner traumatic event, the Medical Examiner must be not		17. Father's Name (First, Middle, Last) 18. Mother's Name (Mary)	First Middle, M		
2121 ild be f Mental markec event,	o Be	1) ONALD U- IVIACKENZIE HARTA Jea Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ITAL ROUTE NUM	per City or Town, Stat	
MD 2 2 shou th and P 27 is r		PHILLIP MARKENZIE 312 WINDSOR CT.	/1		mo 21028
nore, MD 2 ages 1 and 2 shou nt of Heatth and N :: If item 27 is r other traumatic		crematory or other place)	Date ,	20c. Location - City o	r Town, State
Page Page		4 Donation 5 Other Specify: MEMORIAL GARDENS &	006	BEL AI	e, mD
Balti permit. Departn Imports		21. Signature of Funeral Service Licensee 22. Name and Address of Facility ELONS FUNERAL CH		3 Newfor	OR. MO 21050
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.			Approximate Interval Between Onset and
/Medical xaminer	4	Immediate Cause (Final disease a Cardiac arrhythmia			Death
Tank I was	1	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. Dilated cardi myo athy			
	iner	if any, leading to immediate Due to (or as a consequence of):			
ed isit	Examiner	CDisease or injury that initiated events resulting in death) Last CDESITY Due to (or as a consequence of):			
	_	d. Y UNPENDED X AMENDED . item# 23a-c.27.perMF9855.5/12/06 TT			
60, ate be e hysicia e burial	Medi	IF FEMALE: AMENDED item# 23a-c,27,penME.g855,5/12/06 TT 4a.10e per me g85/7-13-06 vt 23c. If yes, outcome of pregnancy		23d. Date of delive	TV TV
Box 68760 e death certificate be the attending physical of for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnan	ісу	Month	Day Year
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transition of the control of the c	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
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Vita hysicia this cer	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing	Home 5 F	Residence 6 🗸 Othe	er: Scene
	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
iSio	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or R	ural Route Number, City
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 44 hours after death. Fureral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the burited burits.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, St		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of one) 7 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at			
To the within 7 To the complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, in my opinion, death occurred at an analysis of examination and/or investigation, and of examination and/or investigation and occurred at an analysis of examination and or investigation and occurred at an analysis of examination and occurred at an	the time, date a	29d Date signed (M	
	-	O.C.M.E.		April 30, 2006	.,, 1
		30. Name and address of person who completed cause of death (Item 23a)			
\mathcal{D}		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		

State Registrar DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 **Physician** 3:00 PM WILLIE MAE STRIGGLES 2006 /Medical 4c. County of Death Prince Georgle's 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Comunity Hospital Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min Days Hours 254-30-3834 1 ☐ M 2 🔀 F 77 Yrs. Director June 19. Georgia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at Yes 2 No Director Maryland Larham Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20706 U.S.A. 7308 Powhatan Street or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after inent of Health and Mental Hygiane. Int: If Itam 27 is marked other than "natural", or ite: 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give maryland 21215-00361 Yes XX No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (Secondary (0-12) Cotlege (1-4or 5+) Sales Clerk Sears Dapartment Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Essie Moore James Jordan 2 19a. Informant's Name/Relationship *(Type, Print)* Mr. Willie D. Striggles (Husband) 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7308 Powhatan Street Lanham, Mary Land 20/06 more, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Harmony Memorial Park permit. Pages Dapartment of Important: If It sny Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 4, 2006 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. maleson 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician anoxic /Medical Due to (or as a consequence of). Examiner rolon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): for use as the burial-transit a consequence of): Due Box 68760 the attending physicien 99 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 Yes No No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (ftem 23a) (Type, Print) eted cause 30 Name and address of person who compl Inda

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Marylan	•	artmen <i>tificat</i>			d Men	tal Hygie	6	106	14.2	61
			1. Decedent's Name (First, Middle, Last)							ate of Death	D		3. Time of	Death
8	Physicia /Medic	S 30	Linda	S	torto					May 4,	Day 20	006 ^{Year}	8:35	Ам
1	Examin	21	4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or I	Location of De	eath			unty of Death	1	
1		Š	101 Center Plac	e Apt 916		Du	nda]	Lk			Ba	altimo	ore	
7	Funeral		Social Security Number 6. Sex	V		If Under Months		If Under 24 H	Hrs. 8. D	Date of Birth Month, Day, Y	ear)	9. Birth	place (State o	r Foreign
н	Director	}	214-56-4898	M 20 F 56	Yrs.				0	ct. 1	7,	9. Birth 1949	Md.	
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside Cit	tv Limits
	f sho	5	Md. Baltim	ore	Dund	dalk							1 🗆 Yes	•
	the the control	Director	10e. Street and Number			10f. Zip	Code			100	. Citizer	of What Cou	intry?	
	an or		101 Center Pla	ce Apt. 916	5			222			US.	A	,	
	Jeath Tra 2:	Funeral		2. Was Decedent Ever in U.		Vas Dece	dent of His	panic Origin?	? (Specify	Yes or No-	14.	Race - Amer		
(0	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No		tYes, spe⊲ 1 ∐Yes			uerto Hicai	n, etc.)		Black, White becify: Wh:		
ё О	reff, c	l by	3 ☐ Widowed 4 🖔 Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	ZEJ NO	Specify:			Sp	ecity:	100	
2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usua kind of wo	al Occupat	tion uring most of	working	16	b. Kind	of Business/li	ndustry	
21	ithin ne. hen "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L		· ·							
7	led w tygier ther th		11 yrs. 17. Father's Name (First, Middle, Last)		<u> </u>	Hous	sewi		Nama /Fin	st, Middle, Ma		ome		
and	be fi	Be	William Clemen	Q					•	tchle		mame)		
ž	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. I and Marid Hygiene le marked other then "nature!", or Items 23a or 28s-f show aumatic event, the Medical Examiner must be notified at	မှ	19a. Informant's Name/Relationship (Typ		19h Mailin	a Addross	(Stroot o			ute Number, C		num Stato Zi	in Code)	
Maryland 21215-0036	ges 1 and 2 should t of Health and Men If item 27 le marke or other traumatic			daughte	200	-				Rd. Or				11117
e)	1 an Heal tem 2		Kimberly Barr 20a. Method of Disposition	20b. P	lace of Dispo	sition (Nar	ne of		Date	20		ion - City or T		1.
ē	ages nt of t: If if		1 ☐ Burial 2 🛣 Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State I	_{emetery, cren} yview			y MA	4y 5,		Bal	timor	·e	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 le eny injury or other trau ance.		21. Signature of Funeral Service License						2006					
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4			23a. Part1. Enter the disease or compli- shock, or heart failure. List only on	cations that caused the ceat									Approximate	9
	Physician		Immediate Cause (Final	A .	4 %	/		in for	-	•			Onset and I	Death
1	/Medical		disease or condition resulting in death)	Due to (or as a conseq				n Max	Clea	// (Hour	2
И	Examiner	Ţ												
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8760,	physic physic s the b	dical	d									-		
9	death certific attending pl	Med	IF FEMALE:									1		
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live birth 2 Feta	ideath 3	Ectopic p					230	 Date of deliving Month 		ear .
o.	the a	yslc	1 ☐ Yes 2 ②No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eatn 5∟	Other (sp	эеспу)							
σ.	that the de ed by the detached		Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying d	ause givei	n in Part I.		23e. Did tobac	cco use	contribute to	the cause of d	eath?
ds,	uires tha signed id be del	d by								1 🗌 Yes	2 🗆 1	No 3 Pro	bably 4 🗀	Jnknown
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e	n: Ti ficate or, pa	e Cc	25. Was case referred to medical					00 Blace of I		performe	No	1 🗆 Yes	2□ No	
Division of Vital Records, P.	Physician: r this certifica ral director, i	8	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	1 3 D	Other			SResidence	-	Other (See	rha)	
ō	a Physer the	٦: T	27. Manner of Death	28a. Date of Injury	28b. Time of		28c. Injury Work			Describe how			",	
<u>o</u>	ath. r: Afe	ato	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	М		es 2 🗆 No						
<u>vis</u>	Attendi ar death ector: A by the fi	IIIC	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factor	y, office		28f. I	ocation (Stree	et and N	lumber or Rui	ral Route Num	ber,
	tal or A s after at Direct	Certification:		ballating, oto. (opposit						ony or . om, .	31410)			
	To the Hospital or Attending Physician: The I within 24 horurs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only 2 Medical Examin	ician: To the best of my known of the basis of examina	wledge, death	occurred	at the time	e, date and pl	lace, and o	the time date	se(s) an	d manner as	stated.	1
	To the H within 24 To the F complete	ledi	one)	and manner stated.										
	Vitto Con	Σ	29b. Signature and title of certifier	M		1	D 3/	. 1				igned (Month		
	Λ		700					700		- 5	, - '	> -01	6	
	1		30. Name/and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)	- n	1//	0-	Sume	in	1 00-1	1 2101	60
in the same	J. market and the second	e de	31. Date filed (Month, Day, Year)	32 Registrar's Signa	J ICO	- AP B	100	141	- ()	June	1	my in	000	
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		For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H <i>rtificate of l</i>			ene 06	14262
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	
/Medic	al		Margar	ret E. S	peaks		4	29 2006	
Examin	er	4a. Facility Name (If not institution, give s Milford Manor	street and number)		Pikesv	Location of Death		4c. County of De Balto	ath
Funeral	- E	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	I O B	inthplace (State or Foreign
Director		224-18-2515	M 2 X 0 F	81 Yrs.	Months Days	Hours Min.	(Month, Day, 3-5-19	25	Va
pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	noation				10d. Inside City Limits
shoved at	o	Md N/A		Balto	ocation				1 Yes 2 No
the A	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (
3a or	Ö	4510 Garden Drive	2			21215		USA	
death	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		nerican Indian,
or the		1 Never Married 2 Marned	1 ☐ Yes 2X☐ No If Yes, Give	0	ir res, specity Cuba 1 ☐ Yes 2 🛣 No	n, mexican, Pueno Specify:	Hican, etc.)	Specify: B	
ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:						
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uid be Menta Menta rrked	To B	Samuel Needum				Maggie	Flecher		
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar mount be notified at once.	•	19a. Informant's Name/Relationship (Ty			_		Balto, M	City or Town, State,	Zip Code)
and lealth m 27 her tr		Alfred S. Speaks	- Son		Winthrope				T
in the state of th		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐R	emoval from State		matory or other plac	e)		Oc. Location - City of Crownsvil	
it. Pa rtmen rtant: njury		4 Donation 5 Other (Specify)		Crownsvi					re, Mu
Depariment on the services		21. Signature of Funeral Service License	F. Thom	pen "	2. Name and Addres	abash Ave	erch F/H enue Bal	West to, Md 21	.215
•		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused to be cause on each line	3.			_	- //	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	ı	Cere	Gral v	a Siulan	GCCY	lest	William
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
petr Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (01 10 11	33,133,133					
execu n and iaf-tra	Exa	that initiated events cresulting in death) Last	Due to (or as a	consequence of):					
icate be executed physician and sthe buriat-transit	edical								
nd ph		IF FEMALE:							
The law requires that the death certific, and the law requires that the death certific are hes been signed by the ettending plage 2 should be detached for use as the last the last last last last last last last last	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of d Month	
at the dea by the en	/slci	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)			MONTH	Day Year
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The lav	Completed	F	Miss the		•		24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
certificate	C	25. Was case referred to medical	UK _			Of Disco of Docal	1 ☐ Yes 2		s 2 No
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urs at prair of led in led in						1			Total Annual Ann
The Hospitel or Attending hin 24 hours after death the Funeral Director: After holetely filled in by the fune	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of ier: On the basis of a and manner stat	my knowledge, deatlexamination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau red at the time, dat	use(s) and manner a te and place, and di	as stated. ue to the cause(s)
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and title of geriffier	and manner stat	ou.	29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
F S F Ö		*	1/11		Di	1569		5/1106	. 1
11		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)			///	
И		Kle	y bett	Once,	1838	Greene	Tree	141	21207
Sta		31. Date filed (Month, Day, Year)		's Signature	9 10 -				3
Registr	ar	MAY 0 5 20	Tibl Re	ACC ACC	200000000000000000000000000000000000000				

DHMH 17 Rev 1/2001

Amend item#23a, b, perM, g855, 5,500 II State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Physician 28, May April 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 314 Foster Knoll Road Joppa Inder 1 Year Harford If Under 24 Hrs. Under 1 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 ☐ M 2 🛛 F Yrs Director 283-01-1589 April 27, 1917 Ohio Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Joppa. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iteme 23a 314 Foster Knoll Road 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ö 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any injury or other traumatic event, the Magnes. College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Niedhamer William Sterne Katherine (nmn) 2 (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Foster Knoll Road, Joppa, Maryland, 21085 Michelle Connor - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brookmere Cem. 5/03/06 Cleveland, Ohio 21. Signature & Funeral & rvice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Atherosclerotic cardiovascular disease Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Horive Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine certificate be executed burial-transit attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2. 2 No 2. No 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Innatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
April 28, 2006 29b. Signature and title of certifier 10043909 MA Linder mance Stephanie Linder 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21085 Joppa,
32 Registrar's Signature mo 31. Date filed (Month State 2006 Registrar

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate o		Mental Hy	/giene Reg. Nö.	106	14264
	*		1. Decedent's Name (First, Middle, Last)					2. Date of D			3. Time of Death
	Physici		Dominic M. Slem	ba				May 2	, 2 ^{Day} 0	6 Year	7:20a ^M
1	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town	, or Location of De	ath	4c. C	ounty of Death	
ſ			Stella Maris Ho	spice		Timon	ium		Ва	1timo	re Co.
	Funeral		Social Security Number 6. Sex	7. Age (M 2□F	(In yrs. last birthday	Months Day			irth ay, Year)	Co.	nplace (State or Foreign untry)
	Director		165-20-9014	M 20 F	79 Yrs.			3-23	-1927	Pen	nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Manyli Paho	5	MD Howard	Co	F11 dest	- City					1 ☐ Yes 2 🗷 No
	28a-	ect	MD Howard 10e. Street and Number		Ellicot	10f. Zip Code	<u> </u>		10a, Citize	n of What Co	untry?
	with with	ā	12300 Folly Qua	rter Roa	a d		-1419		USA		,
	leath	era		12. Was Decedent B			f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or N	L	. Race - Ame	rican Indian,
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show hipportant; or items 23a or 28a-f show hipportant or items of the marked at 2016.	by Funeral Director	1. Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If Yes, specify Co 1 ☐ Yes 2 Mar. N		erto Rican, etc.)		Black, White pec <i>ify:</i> Wh	ite
ğ	2 hou		15. Decedent's Educ	cation	16a. Dec	edent's Usual Occ	upation		16b. Kind	of Business/	
215	Madi	Completed	(Specify only highest grade Elementary/Secondary (0-12)		life.	B KIND OF WORK DOI DO NOT use ret	ne during most of v ired)	vorking			
2	d with	E O	12	College (1-4or 5	Fran	nciscan	Friar		Reli	gious	Order
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<u> a</u>	utd b Ments prked	P	Joseph Slemba				-	Skarbel			01070
Maryland 21215-0036	nd 2 sho alth and 27 Is mu		19a. Informant's Name/Relationship (Ty). Fr. Michael Kol		19b. Mai 1230	ing Address <i>(Stre</i> D Fo11 y	et and Number or Quarte	Rural Route Num.	Elli Elli	rown, State, Z COtt	_{Tip Code)} 21042 City, MD
ore,	of He		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	lace)	Date	20c. Loca	ition - City or	Town, State
Ĕ	Page nent int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 🔀 Other (Specify)	Entombinent			Cem. 5			imore	
Baltimore,	permit. Departr Imports eny inji		21. Signature of Funeral Service License		A 2						al Home, MD 21222
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not en	nter the mode of o	lying, such as card	lac or respiratory	arrest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	PROSTAT Due to (or as	E CANCER a consequence of):						Onset and Death
	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of):						
oʻ	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate be physici	dicai		l							
.O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregna □ Other (specify)			23	d. Date of deli Month	ivery Day Year
rds, P	The law requires that the site has been signed by th bage 2 should be detache	ρ	Part II. Other significant conditions cor	ntributing to death b	ut not resulting in the	underlying cause	given in Part I.		tobacco use		the cause of death?
of Vital Records,	The law re sate has bee page 2 sho	Completed						24a. Wa aut per	opsy formed?	prior to death?	topsy findings available completion of cause of 2 No
ita	icien: certifica rector,	Be (25. Was case referred to medical examiner?				26. Place of D	Death (Check only	олеј		
× ×	<u>\$</u> .≅ 5	ှင	1 ☐ Yes 2 X No	lospital:		TIL JU DOA					HOSPICE
	nding ath. r: After e fune	Certification:	27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigation	28a. Date of inju (Month, Day	y Year) 28b. Time Injury	V	njury at Vork? ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred	
Division	al or Atte s after des Il Directo id in by th	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, etc.	ury - At home, farm, s c. (Specify)	treet, factory, offic	C8		(Street and own, State)	Number or Ru	iral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical			of my knowledge, dea examination and/or ited.						
	To th withir To th comp	M	29b. Signature and Ittle of certifier				43725	_		signed (Monti	4
	10		30. Name and address of person who co	empleted cause of d	eath (Item 23a) (Type					/ / /	
	U		DR. TARIO MAHMOO		DULANEY VA		TIMONI	UM, MD 2	1093		
	Sta	ate	31. Date filed (Month, Day, Year)	32. 199 str	ar's Signature	0-0-					
	Regist	-6	27. 4 0 5 20	106	w to the	code					

DHMH 17 Rev 1/2001

MAY 2, 2006 7:20 a.m.

DOMINIC SLEMBA

Physician /Medical Examiner **Funeral** Director 10a State or 28a-f show traumatic event, the Medical Examiners rust by notified at Director MD items 23a Funeral is marked other than "natural", or þ Hygiene. should be find Mental 1 Known as Department of Health Important: If item 27 l any injury or other once.

1 - For State Registrar

/Medical Examiner certificate be executed burial-transit attending physician use as the jo been signed by the should be detached

2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month 0 2006 7.30 A M GERALD THOMAS 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE SINAI HOSPITAL BALTIMORE OF CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours Months 1**X** M 2□ F 52 3-11-1954 218-60-4486 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XXYes 2 No BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 N. HILTON STREET 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. □Yes 2XNo 1 XX ever Married 2 Married 1 Yes 2X No Specify: If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOME IMPROVEMENT LABORER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PAULINE ISAAC JESSE THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 N. HILTON STREET BALTIMORE, MARYLAND 21229 PAULINE BRUTON/MOTHER Date 20c. Location - City or Town, State 20b Place of Disposition (Name of Marie OLL) ace) 20a. Method of Disposition 1 Surial 2 ★ Cremation 3 Removal from State
1 A Donation 5 Other (Specify) BALTIMORE, MARYLAND ARBUTUS MEMORIAL PK. 5-8-06 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee BALTIMORE, MARYLAND 21217 1701-31 LAURENS ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AIRWAY OBSTRUCTION JPPER Physician disease or condition resulting in death) Due to (or as a consequence of): LOCALLY ADVANCED Secondary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner TONGUE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3℃ Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 77 No certificate the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပို this Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined á 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Christian Monshall D0063500 MAY 2. 2006 MD PAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE SINAL HOSPITAL OF Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

		í	1 - For State Registrar	of Marylar		artment of rtificate of	Health and No. 1 Death		giene	6	14266
	Physici	an	Decedent's Name (First, Middle, Last) Charles		Thic	ker		2. Date of De		Year /	3. Time of Death HIDA M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and	Jumber)	tal		or Location of Death	41/	4c. County		7.107
	- Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. 81	last birthday, Yrs.	Hunder 1 Yea Months Day		B. Date of Bir (Month, Da	ıy, Year)	9. Birthp Cour	place (State or Foreign ntry) Va.
	ryland show		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or L					1	0d. Inside City Limits
	after death with the Marylar or items 23e or 28a-f show miner neat be notified at	Director	Md. NA 10e. Street and Number		Ва	10f. Zip Code			10g. Citizen of	What Coul	
X	th with	ai Di	2217 Cecil Ave.			21	218		USA		
W	er death w Items 23e	uner	Armed	cedent Ever in U Forces?	.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Rad Bla	ce - Americ ck, White,	
× 036		by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Ye If Yes, 3 ☐ Widowed 4 ☐ Divorced Year or	s 2 □ No Give Dates:		1 ☐ Yes 2 🔀 N	o Specify:		Specil	y: E	lack
75.	n 72 h "natu	ietec	15. Decedent's Education (Specify only highest grade complete	d)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of work	ain g	16b. Kind of B	usiness/In	dustry
212	d within giene.	Completed	Elementary/Secondary (0-12) Coltege 8th grade	(1-4or 5+)		late Mil			Bethel	hem S	teel
and	s 1 and 2 should be filed within 72 hours Health and Mental Hygiene. Item 27 Is marked other than "natural", other treumatic avent, tre Medical Exa	To Be C	17. Father's Name (First, Middle, Last) Geroge	Tucker			18. Mother's Nam	e (First, Middle 'empe		™) Royal	
ary	2 should and Men Is marke eumatic	1	19a. Informant's Name/Relationship (Type, Print)				et and Number or Rui				
e, R	s 1 and 2 f Health item 27		Charles C. Tucker	30b. 1	_		yfalls Way	, Baltı Date	.more, M		21236 own, State
₹ P	Pages nent of l int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State		osition (Name of matory or other p n Forest	1	-06	Owings		
Balti	permit. Pages Depertment of important: If i any injury or once.		21. Signature of Funeral Service Licensee	مس		2. Name and Add March F	ress of Facility .H. East		nore, Md E. Nort		
3.5			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	t caused the dear	th. Do not en	ter the mode of d	ying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CUMO (or as a consec	mia						
	Examiner		Service tiethe liet acceptions	ing CC	MAC	~					
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V	cate be executed by sician end the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consec	quence of):	UL (III	TUITTUTE	ry	1150015		
8760,	cate ohy:	dicai	d								
9	eath certific attending p	0	230. Was decedent pregnant	outcome of pregn		⊒Ectopic pregnar	acv.			ate of deliv	•
P.O. Box	that the deatl ed by the atte detached for	by Physician/M		gnant at time of o		Other (specify)			M	onth	Day Year
	quires that n signed b uld be det		Part II. Other significant conditions contributing to	death but not res	sulting in the	underlying cause	given in Part I.		tobacco use con Yes 2 □ No	_	he cause of death?
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was auto perfe		Were autoprior to codeath?	psy findings available impletion of cause of
/ital	sicien: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
of \	Physi r this c sral dire	10	27 Manner of Death 28a, Da	te of Injury	ER/Outpatie	III 3LI DOA			idence 6 □Oti how injury occu		(y)
ion	attending Phi death. ctor: After thi y the funeral o	ation	2 Accident investigation	onth, Day Year)	Intury		/ork? ☐Yes 2☐No				
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To Check only one) 2 Medical Examiner: On the and m								
	To the within To the compl	We We	29b. Signature and title of certifier			29c. Lice	ense number	=110	29d. Date signe	ed (Month,	Day, Year)
			A CONTRACTOR OF THE PARTY OF TH	HUKN	-	7	89	249	April	DU	, 2006
	10		30. Name and address of person who completed control of the completed control of the completed control of the c	WU	m 23a) (Type	2/0/	Marylan	160	neral	HO.	spital
1	Sta Regist		31. Date filed (Month, Day, Year) 32	Registrar's Sign	ature .	we					

		•	For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygiene	006 14267
			1. Decedent's Name (First, Middle, Las	at) A		2. Date of Death	3. Time of Death
	Physici /Medio		ALLEI	J C,	Thomas	Month Day	2006 12 5mm
	Examin		4a. Facility Name (If not institution, give Bon Secons Hos	street and number)	4b. City, Town, or Location of Deat	h / 4c. (County of Death
	Funeral Director		4527-1710	x 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dayy Year)	9. Birthplace (State or Foreign Country)
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the h	Director	10e. Street and Number 1241 EVIN	RIZ.	10f. Zip Code	10g. Citiz	en of What Country?
10	fer death r Itams 23 frec r us	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 7 s 2 No	If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	4. Race - American Indian, Black, White, etc.
-0036	Phours at stural, or	<u>주</u>	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates: lucation	1 ☐ Yes 2 ☐ No Specify:		Specify: DACK d of Business/Industry
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then 'natural', or Items 23a or 28a-f show ont, the Medical Examinational be notified at	Completed	(Specify only highest gra	College (1-4or 5+)	(Give kind of work done during most of worlife. DO NOT use retired) AND TOWNS OF THE RESERVE TO SERVER TO		bapital
Maryland 3	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "natural", or items 23s or 28s-f show item 27 is marked other then "natural", and item and item will be a millied at	To Be C	17. Father's Name (First, Middle, Last)	THON	18. Mother's Nar ROSE 7	ne (First, Middle, Maiden S	Sumame)
	1 and 2 sho Health and N tam 27 Is ma		19a. Informant's Name/Relationship (1	ype, Print)	19b. Mailing Address (Street and Number or Ru	Iral Route Number, City or	Town, State, Zip Code) 21229
Baltimore,	e = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 9 ☐ Other (Specify	Removal from State	ce of Disposition (Name of netery, crematory or other place)		ation - City or Town, State
Balti	permit. Pag Department Importent: any injury once.		21. Signature Puneral Service Light		22. Name and Address of Facility of	TO TEDAIL	1 4 Post 11229
	Pnysician	·	Immediat - Cause (Final	olications that caused the death.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequent	nce of): We at farlu	10	2000
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cauce. Enter Uncertying Cause (Disease or injury that initiated events	Due to (or as a consequent	nce of):	estion	Julea
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consequent	nce of):		
.O. Box 68	ne death certif the attending hed for usa a:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant al time of deal 9 □ Unknown	eath 3 □Ectopic pregnancy	2:	3d. Date of delivery Month Day Year
Δ.	uiras that the signed by the signed by the detaction in the detaction in the signed by	þ	Part II. Other significant conditions of	entributing to death but not resulting to Management	ing in the underlying cluse given in Part I.		e contribute to the cause of death?
of Vital Records,		Completed	closure	or gastu	te ulcer 5/106	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ௸Yes 2 □ No
/ita	cien: ertific ector,	Be (25. Was case referred to medical examiner?			th (Check only one)	
n of \	<u> </u>	2	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending		8b. Time of 28c. Injury at Work?	ome 5 Residence 6 28d. Describe how injury	
Division	l or Attend after death Director: A	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
TAL.	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical Ce			edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occu		
	o the	Me	29b. Signature and title of certifier	٢	29c. License number	29d. Date	signed (Month, Day, Year)
)			> Kwang x	- Kin	NIDOZI	5/	4106
19	51		1/2 IA In a Y VC	completed cause of death (Item 2	3a) (Type, Print) W. Rult muono St. 7	saffenis A	10 21223
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2	32. Popistrar's Signatur	& Knowled	11-10-1	

		•	1 = For State Registrar	State of M	Maryland / Dep	ertificate of l			giene Reg. No.	6	1268
	Physici	an	Decedent's Name (First, Middle, Last Adeline) _M	п	'auber		2. Date of De Month	Day 2006	Year	3. Time of Death 9:45 AM
84	/Medic					4b. City, Town, or	Logation of Door		4c. County		9.43 A
7	Examin	er	4a. Facility Name (If not institution, give 7212 Birch Ave.		'')	Dunc		u 1		ltir	nore
400			5. Social Security Number 6. Se		Age (In yrs. last birthda	/) If Under 1 Year	If Under 24 Hrs	8. Date of Bir	1		place (State or Foreign
7 1645.	Funeral Director			⊒M 2 ∑ F	84 Yrs.	Months Days	Hours Min	8. Date of Bir (Month, Da December	12, 1921	PA.	ntry)
	P		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	a cation					10d. Inside City Limits
	toges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, the Medical Examinat must be notified at	5			Dundal						1 □ Yes 2 □ No
	the M	Director	MD. Baltimor	е	Duridati	10f. Zip Code			10g. Citizen of	What Cou	
	3a or		7212 Birch Avenue				222		USA		
	ms 2	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No)- 14. Rad	ce - Americ	can Indian,
9	after or Ita		1 Never Married 2 Married	1 Tes 2 If Yes, Give	Χνο	1 ☐ Yes 2 🛱 No	Specify:	to ritouri, sto.,	Specif	_	
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates					16b. Kind of B	AATT	ite
5-	n 72 n	iete	15. Decedent's Ed (Specify only highest grad	de completed)	(Giv	edent's Usual Occup re kind of work done o DO NOT use retired	during most of wa	orking	160. KIIIG OI B	usiiiess/iii	laustry
212	iene. r than "	Completed	Elementary/Secondary (0-12) 10 years	College (1-4o	r 5+)	ousewife			Own H	iome	
פו	e filed al Hygi other vent, t	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden Sumar	ne)	
Vlar	should be nd Mental marked o	10	Joseph Rapski					Giblock			
Maryland 21215-0036	2 sho	0 1	19a. Informant's Name/Relationship (7		Grand	iling Address (Street					
	1 and Health tem 27		Bruce La Folle 20a. Method of Disposition	tte Jr.	son 200 20b. Place of Dis	Homberg A	venue, 1	ESSEX, Ma Date	20c. Location	212.	
Jor	Pages I nent of H ant: If Ite		1 Sp Burial 2 ☐ Cremation 3 ☐		cemetery, ci	ematory or other place Ll Memoria		6,2006	Middle		
Baltimore,			4 ☐Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		OITY III.						
Ba	permit. Departi Import. any inj		23a. Part! Enter the disease, of compshock, or heart failure. List only of	C. C	omilly	Connelly 7110 Soll	ers Poir	nt Road,	Dundalk	,P.A ,MD.	21222 Approximate
760,	Physician with Medical Examiner with principle	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Core Due to (or a	as a consequence of): as a consequence of): as a consequence of):						Onset and Death
P.O. Box 68	The law requires that the death certificat ite has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal death : at time of death	B Ectopic pregnancy Differ (specify)	,			ate of deliv	ery Day Year
	uires that n signed b	þ	Part II. Other significant conditions of	ontributing to death	n but not resulting in the	underlying cause giv	en in Part I.				the cause of death? bably 4 Blanknown
Records,	The law requisite has been page 2 should	Completed				.		24a. Was auto perfe 1 Yes	s an 24b. ppsy ormed?	Were autoprior to codeath?	opsy findings available ompletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					eath (Check only	one)		
of V	Physician: this certificanal director,	2	1 ☐ Yes 2 ☑ No		atient 2 ER/Outpat		4 Nursing	Home 5 Res			fy)
	ding After fune	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		njury 28b. Time <i>Day Year)</i> Injur	Wor	yat k? Yes 2∐No	28d. Describe	how injury occu	rred	
Division	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	288. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office			(Street and Num own, State)	ber or Rur	al Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai (est of my knowledge, des s of examination and/or stated.						
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signe		
			A Soudh	aran		· >c	0 6316	4	MAY 3	,2	006
	12		30. Name and address of person who	completed cause of	of death (Item 23a) (Type	e, Print)	TIMOR	E MIT	> 212		
	St Regist	ate rar	30. Name and address of person who 5505 Hopk IN 31. Date filed (Month, Day, Year) 2	006 32 Regi	istrar's Signature			,			

			For		f Marylan	d / Depa	artmen	t of H	ealth a	and M			_	and and a second	269
1			= State Registrar			Cei	tificat	e or t	Jeath			Reg. No	ليا ليا ليا.	76	
	Physicia	_	 Decedent's Name (First, Middle, La 	st)							2. Date of Dea Month	ath Da	y Year		of Death
	/Medica	al .	B. Eileen Toch								MAY	3	2006		124-W
	Examine	er	4a. Facility Name (If not institution, giv			0 4			Location			4c	. County of Deat	th	
		.31			H CA				IMO						
10	Funeral		5. Social Security Number 6. S	Sex 1 □ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Birt (Month, Da	y, Year)	9. Birt	hplace (State	e or Foreign
14	Director	-	218-01-2619 Usual Residence of Decedent		86	113.					Sept. 2	20,1	919 Mar	yLand	
	pue *	-	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
	Aaryli sho	ŏ .	1 1 77 1			11.								1 □ Y	es 2⊠ No
	28a-1	Director	Maryland Howard 10e. Street and Number		E.	llicot	10f. Zip					10a. Cit	izen of What Co	ountry?	
	with			1 7701	_			2104	2			-	SA	,	
	eath	Funeral	3004 N. Ridge Ro	12. Was Dec	edent Ever in U	.S. 13.				igin? (Spe	cify Yes or No		14. Race - Ame	nican Indian,	
	ter d itan	5	1 Never Married 2 Married	Armed Fo	orces?						cify Yes or No Rican, etc.)		Black, Whit		
336	irs af	þ	3 Widowed 4 Divorced	1 □Yes If Yes, Gi Year or D	ve ² Dates:		1 🗌 Yes	2X No	Specify:				Specify: Whi	Lte	
Š	2 hou	ed ed	15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occup	ation			16b. K	ind of Business	/Industry	
75	7 nin 7	be	(Specify only highest gri	College (lite.	kind of wo DO NOT u	rk done d se retired	during mos i)	t or workii	ng				
217	d with	Completed	12			Admin	istra	tive	Assi	istan	t		Reta	il .	
Þ	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itams 23s or 28s-f show event, the Maryland Examican mant be notified at	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle.	Maider	Sumame)		
<u>a</u>	Alenta Alenta riked tice	2	John Thomas Wic	k					Aug	gusta	M. Cha	ar1t	on		
ar _Z	short Name		19a. Informant's Name/Relationship	Type, Print)			•					-	or Town, State, .		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other treumatic event, the Marylon Examinator must be notified at once.	-	William Tochterma	n Hu	sband	3004	N. R	idge	Road			lico	tt City	, MD	21043
re	s 1 s of He item	3	20a. Method of Disposition		,	Place of Dispo cemetery, cre	natory or o	ne of ther plac	(e)	D	ate	20c. L	ocation - City or	Town, State	
Ĕ	Page Pent Int: If	1	1 Burial 2 Cremation 3 4 Donation 5 Other (Speci			tro Cr	emato	rv	ا ا	5/4/2	006	Cato	nsville	. Marv	land
E E	mit. Partn Sorta / Inju		21. Signature of Furnatal Service Lice	nsee	1//	7/ 2	2. Name ar	d Addre	ss of Facili	y Ste	rling A	Asht	on Schw Inc.	ab Wit	zke
m	Department of the service once		MA	2/1	014	1	630 E	dmon	idson	Aven	ue: Cai	tons	ville,	MD 212	28
8	9		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the deat									Approxin	nate
_	Physician		Immediate Cause (Final		_OSTRI	DIUM	DI	FEL	CILA	2 (OUTIE			Onset ar	
	/Medical		disease or condition resulting in death)		(or as a consec			-			1112	•		Ø I	111/3.
5	Examiner		vakakominia akvismosa ili umi				TRO	KE						10	16:Y
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211 -			resulting in death) Last	Due to	(or as a consec	uence of):									
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9 k	tifica ng ph as th	Med													
Box 68	th cer endir r use	2	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnation		∃Ectopic p	regnancy	,				23d. Date of de		Waas.
8. a	deat	100	in the past 12 months? 1 ☐ Yes 2 XNo		nant at time of o		Other (sp						Month	Day	Year
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M M ords	en si	ed									1 🗆 '	Yes 2	□No 3□P	robably 4	⊠Unknown
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TE R	sician: The law certificate has b lirector, page 2 s	Completed									perfo	rmed?	death?	4.	. 02000
Cd 7 Vital	an:	BeC	25. Was case referred to medical						26. Place	e of Death	(Check only o	_/_			
\(\sigma\) \(\sigma\)	Physician: r this certific ral director,	일	examiner? 1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 D0	Oth Oth	er: 4 🗆 No	ursing Hor	me 5 ☐ Resi	dence	6 Other (Spe	ecify)	
0	g Ph ler th	<u> </u>	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	1 2	28c. Injun Wor	y at	2	28d. Describe	how inju	ry occurred		
<u> </u>	Attending r death. ector: After	atlo	1 Natural 5 Pending 2 Accident investigation	on			М		Yes 2	No					
Division	er de recto by th	1111	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	289. Plac	e of Injury - At h		reet, lactor	y, office		1	28l. Location (City or To	Street a. wn, Stat	nd Number or R e)	ural Route N	umber,
Ö	tal or s afte el Dir ed in	Certification:													
			29a. Certifier 1 Certifying P (Check only 2 Medical Exa												e(s)
	the H in 24 he F plete	Medical	one)		nner stated.										
	To T To I	≥	29b. Signature and title of certifier	0			29	_	e number				ate signed (Mon		
			Sweech	ala.				17	199	23		M	AY, 0	3,20	06.
-	10		30. Name and address of person who	completed cau	ise of death (Ite	т 23а) (Туре	Print)	0.0		1	0 01		001-		
_	[0]		SCUARCHAL				51.	+141	NEZ	1105	PITHL	-)	BHLIIM	UKE	MD
	Stat		31. Date filed (Month, Day, Year)		Registrar's Sign.		B	<i>P</i> -							
	Registra	ar	MAY 0 5	2006	A BULL	1	1346								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician VAUGHN 2006 4-30 AM A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wickham Baltmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Min 1 ☐ M 2 🔀 F 216-42-9719 January 20, 1944 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location Show the Medical Examination at the notified at 1 Yes 2 No Bal Hmore MD Director or 28e-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21229 605 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 "naturel", or Specify: AFRICAN Amendo 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of manyla Clerk of Health and Mental Hygie litem 27 is marked other r other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be A. Williams Willie Blanche (greene e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 605 S. Wickham Road Baltmore MOZIZZ9 nt of Health a haron L. Vaughn/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 DeBurial 2 Cremation 3 Removal from State ö troutus MemorialPk 5-9-06 permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility se Funeral Service, P. H. 5126 Belan Road, Battmure ND 21 21. Signature of Funeral Service Lio. Battmore MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** anoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Hospitel or Attending Physicien: 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 🗙 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 To the I 29b. Signature and time of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

3455

BASKARAN

WILKENS AVE

State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Re	g. No.	146/1
	Dhusiaian	1. Decedent's Name (First, Middle, Last)				2. Date of Deet Month	Dev . Year	3. Time of Death
	Physician /Medical	C. Rudolph van Doe	_			MAY	2nd 200	6 3:55AM
<i>)</i> . (Examiner	4a Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or L		4c. County of Dec	
		Brightwood Center	17.4	in the Miller of Your	Luthervil		Baltimor	
	uneral rector	10, 32 2,11	M 2□F 83	Yrs. Months Deys		8. Date of Birth (Month, Dey, Jan 20,	Year) 9. Bi	rthplace (State or Foreign country) donesia
bue	2	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
Marys	o sh	Maryland Baltimore	e County Cocke	ysville				1 ☐ Yes Ž∏No
the the	- E E	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	country?
¥i.	r items 23a or 28a-f s niner must be notified Funeral Director	10137 Charrington	Road	21030		U	nited Sta	tes
deat	ner ner	11. Marital Status 1	Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Am Black, Whi	
aryiand 21215-0020 shouid be filed within 72 hours after death with the Marylend ind Mental Physiene.	merked other than "natural", or items 23a or 28a-f show imetic event, the Medical Examiner must be notitied at To Be Completed by Funeral Director	1 ☐ Never Married 2 Å Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No		nican, etc.)	Specify: W	
5-0	ated lead	15. Decedent's Educ (Specify only highest grade	ation 16	e. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	petion	kina	6b. Kind of Business	3/Industry
21215-0020 d within 72 hours af giene.	irked other than "nature itic event, the Medical I To Be Completed	Elementary/Secondary (0-12)		<i>life. DO NOT use retire</i> ce President			West Pac	2
₽ ₹	vent,	17. Fether's Neme (First, Middle, Last)	Tran Danahumah			ne (First, Middle, N		
aryland should be file	To E	Everhardus Brandts	van boesburgn		Emma W11	helmina	Rudolph	
₹ 2 E	7 is	19a Informant's Name/Relationship (Type Mrs. Vera van Doesh		9b. Mailing Address <i>(Stree</i> 0137 Charrin				zip Code) yland, 21030
altimore, mit. Pages 1 er pertmant of Hee	O	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	of Disposition (Name of tery, crematory or other pla S Funeral Ch	·		oc. Location - City of ForestI	r Town, State HillMaryland
Balti permit.	important: any injury 2008.	21. Signature of Funeral Service License	Lozu	Peaceful ^{Add} 2325 York	Tternativ Road Timo	es Funer nium Mar	al&Cremat: yland 2109	ion Ctr.P.A.
		23a. Pert 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do	o not enter the mode of dy	ing, such as cardiac	or respiratory erre	st,	Approximate Interval Between
Phy	sician	orden, or rear tallers. Electrically silver	o dado on dasir into.					Onset and Death
	edical miner	Immediate Cause (Final disease or condition	FAILUR	RE TO	THR	IVE		DAYS
LAG		resulting in death) a.		a consequence of):			. 05-	
D ₀	nsit	b .	CORONA		RYERY	D13	EASE	YEARS
), execu	physicien end is the buriel-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	R EN AZ	e consequence of):	100.00	- (-)	,	
6876U	slcier e buri	Cause (Disease or injury that initieted events		a consequence of):	SFACI	ENCY		YEARS
at Se		resulting in death) Last	Due to (or as a	consequence or.				
BOX	ending r use e	d.						1
- de -	ed fo	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying cause g	iven in Part I.	23b. Did to	pecco use contribut	te to the cause of death?
Ords, P.O. BOX 68/60, requires that the deeth certificate be execut.	igned by the ettend be detached for us by Physiclan/	41.1				1 □ Ye	8 2□No 3□F	Probably 4 Unknown
Kecords, ne lew requires th	should thould					24a. Was ar perform		. Were autopsy findings available prior to completion of cause of death?
	bege Corn					t∐Ye	8 SLINU	1 ☐ Yes 2 ☐ No
	is certificate has t director, pege 2 s To Be Compl	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only on	9)	
	To I	1 Yes 2 No	ospital: 1 Inpatient 2 ER/C	Jutpatient 3 DOA		ome 5 Reside	nce 6 □Other (Sp	acify)
ב פֿי	unera unera on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year) 28b	. Time of 28c. Injury Wo		28d. Describe ho	w injury occurred	
VISION Attending or deeth.	the f	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00. 51		Yes 2□No	DDA Lasation (Ct	and and blombar as f	2 mi Davida Musebas
DIVISION at or Attending atter deeth.	al Director: After this of led in by the funeral direction: To	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	tarm, street, tactory, οπισε		City or Town	eet and Number or F , State)	lurai Houte Number,
Hospita 24 hours	Funer tely fii ical		cian: To the best of my knowledger: On the basis of examinetion eand manner stated.					
To the	Ned	29b. Signature and title of certifier		29c. Licen	ise number	25	d. Date signed (Mon	ith, Day, Year)
	~	Shent	e MD	DOC	5315	0 1	1A4 370	1 2006
6) Y	30. Name and eddress of person who con) (Type, Print)			5017	EILO ZIOYS UMBIA
	/	ShArenn.MAZ		9659-51	tn7iAG	0 (LOA	D cou	J MBIA
	State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Market				

State

Registrar

32. Registrar's Signature

MAY 0 5 2006

06-02839 Eric R. Woolford

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

ne it. woonerd		For State	Otate of	War ylaria /		ficate of Death			Reg. No.	0.16	14273
Physician	1/ 1	Decedent's Name (First	, Middle,Last)	1.00	/.)	olford		2. Date of De Month April 26,	ath Day	Year	3. Time of Death 2100 hrs
Medical Examin		a. Facility Name (if not in	nad C	reet and number)	000		own, or Location of De			unty of Death	21001110
		2517 Mosher Str				Baltim	ore			N/A	
Funeral Director	5	Social Security Number	0.11		e (In yrs. last	birthday) If Unde Months Yrs.		Hrs. 8. Date of B	31.19°	Foreign	
	_	Isual Residence of Dece	dent				 	1710,011			7.10
Maryland 28a-f show any d. at once,	1	Oa. State 10b. C	county	1		own or Location				1	10d Inside City Limits 1 Yes 2 No
aryland 8a-f sho at once.	힑_	0e. Street and Number	1 1 7	4	150	altimore 101. Zipi	Code		10a. Citizen	of What Coun	7
tifie	ă D	2517 W.	Mosne		et		21216			usa	
leath wit	売 I	Marital Status Never Married 2		2. Was Decedent Armed Forces? Yes 2			nt of Hispanic Origin? Cuban, Mexican, Pu			White, etc.	an Indian, Black,
after (Ď_	3 Widowed 4	0	Yes, Give Year Dates:	`		No specify:				ack
136 hin 72 hours at te. than "natural edical Examin	ted	15. Decedent's Education Elementary/Secondary		highest grade com		6a. Decedent's Usual (during most of work	Occupation (Give kind king life. DO NOT use			of Business/Ir	
5-0036 led within 72 hours ar Hygiene than "hatural other than "hatural other than "hatural other than "hatural other than "hatural other than "hatural other than "hatural other than "hatural other than "hatural other than "hatural" other t	Completed	Elementary/ Coccinacity	(0 12)	Gyrs		Mid Leve					lotors Co.
21215-0036 Juld be filed within 7 Mental Hygiene in marked other than cevent, the Medics		7 Father's Name (First,	4	6 1		- · · ·		lame (First, Middle			1
2121 uld be fi Mental markec	e O	9a. Informant's Name/Re		Print)		19b. Mailing Address	(Street and Number	ndolyN or Rural Route No	imber, City o	r Town, State,	Zip Code)
			M. Sh	1	- 2	1301 Der	vbright 1	Rd Cato	NSville	e Md	21228
re, M s 1 and 2 f Health If item 2 er traum	- 1	20a. Method of Disposition	n		cre	matory or other place)		1 4			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 O	ther Specify:		Gre	22. Name and	Trematory?	5/4/06	(Bal	rimore	Md
Baltimo permit. Page Department of Important: injury or oth	2	21. Signature of Funeral	Service License	Э			Address of Facility L				Home
Physician	1	23a/Part I. Enter the dise	ase, or complic	ations that caused	the death. D	o not enter the mode of	f dying, such as card	ac or respiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner	1	failure. List only one Immediate Cause (Final o			rotic c	ardiovascular	disease con	plicated b	y gastro	ointesti	al henorrhage
Zammer	1	or condition resulting in c	leath) Du	e to (or as a cons	equence of):						
No. yes	je	Sequentially list condition if any, leading to immedia	ate Du	e to (or as a cons	equence of):						
	티	cause. Enter Underlying (Disease or injury that ini events resulting in death	tiated c.	e to (or as a cons	equence of):						
ecuted and - transit	- 1		d			07 ME 005	T T /00 /00 IIII				
760, cate be exemphysician	Medical	X UNPENDED				,27,perME,G85	5,5/23/06 11		Tool D		
876 tificate ng phy as the		F FEMALE: 3b. Was decedent pregn past 12 months?	antin tha	23c. If yes, outcom 1 Live birth	ne of pregna	ncy 2 Fetal death	3 Ectopic pr	egnancy		ate of delivery onth D	ay Year
Box 687 E death certification at the attending and for use as t	Physician	1 Yes 2 No 9	Unknown	Pregnant at 9 Unknown	time of deat	h 5 Other (Spec	cify)				
D. B.	P.	Part II. Other significant			h but not res	ulting in the underlying	cause given in Part I	23e. Dio	tobacco use	contribute to t	he cause of death?
ires that the signed by	d b							1 Y	es 2 N	o 3 Prob	ably 4 🗸 Unknown
Sords, law requir has been s	Completed						=		opsy	prior to c	opsy findings available ompletion of cause of
Vital Recol	Ē							1 ✓ Yes	formed?	death? 1 ✔ Ye	s 2 No
cian:	Be l	25. Was case referred to examiner?	—	spital: 1 Inneti			OA Other N		Docidones	e 6 🗸 Other	Cana
of Vi ing Physi After this	라	1 Yes 2	No	28a. Date of Inj	ury 2		28c Injury at Work?	28d Describ			Scerie
OD C ending ath. or: Af	ţi	1 X Natural 5	Pending	(Month, Day,	rear)		1 Yes 2 N	p			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that trs after death. 'al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	2 Accident 3 Suicide 6	Investigation Could not be	,	njury - At hon	ne, farm, street, factory	, office building, etc.	28f. Location or Town		Number or Ru	ral Route Number, City
D) ospital hours a		4 Homicide 29a. Certifier	determined	(Specify)		de the second of the	time data and place	and due to the or	use(s) and m	nonnor an start	od
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Chook only	cal Examiner: 0	n the basis of exa	mination and	e, death occurred at the d/or investigation, in my	opinion, death occur	red at the time, da	te and place,	and due to the	e cause(s)
	ğ	29b. Signature and title o		and manner stated		290	c. License number			e signed (Moi	nth, Day, Year)
		Theor	he de	1 Xi	8 ~	112	O.C.M.E.		April 2	27, 2006	
1		30. Name and address of Theodore King I		mpleted cause of stant Medical			et, Baltimore, M	ID 21201			
	400	31. Date filed (Month, Da	y, Year) 5 2.006	2. Registr	ar's Signatur	- Associal					
Regist	ar	- MAY (5 2.000	VALUE OF STREET		- /					

J
68760,
Box
P.O.
Records,
Vital
on of
Divisio

	Physici (Madic		For Amend Item#17 Registrar #26 1. Decedent's Name (First, Middle, Last) Leslie Joseph	Wisniews		Cer	tificate o	f Dea	ath	2. Date of De Month April			3. Time of Death 4:45 p M
	/Medic Examin		4a. Facility Name (If not institution, give st 13303 Tyla Lane	reet and number)			4b. City, Town		ation of Death	<u> </u>		County of Death	
1962	Funeral Director		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Day	ar If U	ours Min.	8. Date of Bi (Month, Di NOV 21			olace (State or Foreign MD
200	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation						0d. Inside City Limits
	Be-f sho	ctor	MD Baltimore		Baldw	vin .							1 ☐ Yes 2 🔀 No
	with the	Funeral Director	10e. Street and Number 13303 Tyla Lane				10f. Zip Code	, 2101	1 2			zen of What Coul USA	ntry?
	death	nera		2. Was Decedent Amed Forces?	Ever in U.S.	13. V	Vas Decedent o Yes, specify Ci			ecify Yes or N		14. Race - Americ Black, White,	
36	irs after il', or Ite	by Fu	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	64 - 67	ł	☐ Yes 2 🛣 N		өсіfу:	Tilouri, oto.,		Canaibu .	ite
2-00	72 hounatura		15. Decedent's Educa (Specify only highest grade		16	(Give I	ent's Usual Occ kind of work dor	ne during	most of work	ing	16b. Kir	nd of Business/In	dustry
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other treumatic event, the Medical Examinatinating to notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) E1	life. L	or Mech	red)			Elev	vator Co	nstruction
pue	2 should be filed with and Mental Hygiene. is marked other that sumatic event, the	Be	17. Eather's Name (First, Middle, Last) Joseph John John Joseph Wi	sniewski					Mother's Nam H il da	e (First, Middle Kathe		Reidv	
ary k	should nd Mer marke matic	은	19a. Informant's Name/Relationship (Typ		19	b. Mailin	g Address (Stre					Town, State, Zip	Code)
	and 2 salth a n 27 is er freu		Bonnie Wisniewski	- wife	1	13303	B Tyla I	ane,			210		
Baltimore,	e 2 = 5		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Re	moval from State	cemet	ery, crem	sition (Name of natory or other p			Date		cation - City or To	
äţi	nit. Pa vartmen oortant: injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	Э	Cnesa		te Crema FA, Ste					tsville	, MD
Ä	permit. Depart Import any inj		+ Statue		_M00986	87	717 Gree	en Pa	astures	<u> Drive</u>	, Tow	vson, MD	21286
- 44			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each li	the death. Do						/	1 6 1	Approximate Interval Between Odset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence		NON SY	nAu	L CEL	LUN	6- C	ANCER	4 MONTHS
	Examiner		Sequentially list conditions, b.										
1	bed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):							
v o	executed an and rial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as	a consequence	e of):							
6876	cate be physicii the bu	dicai	d.										
P.O. Box 6	Attending Physician: The law requires that the death certificate be orderth. orderth: ector: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the buri	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal dea		Ectopic pregna Other (specify)				2	23d. Date of deliv Month	ery Day Year
	ires that I signed by d be deta		Part II. Other significant conditions cont	ributing to death b	ut not resulting	g in the ur	nderlying cause	given in	Part I.				he cause of death?
Records,	e taw requ has been ge 2 shoul	Completed								24a. Wa	s an opsy formed?	24b. Were auto	opsy findings available impletion of cause of
Vital F	ician: The certificate l rector, pag		25. Was case referred to medical						Di (10	1 ☐ Yes	2 7 No	1 Yes	2 No
Ξ	ysicia Is cert directo	To Be	avaminer?	ospital:	ent 2 ER/O	Outpatien	t 3 DOA	Other	1/			6 □Other (Speci	(y)
0 0	ing Phys After this uneral di		27. Mann Death 1 Patural 5 Pending	28a. Date of Inju (Month, Da	ry 28b y Year)	. Time of Injury	V	Vork?	O DNo	28d. Describe	how injur	y occurred	
Division of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At home, c. (Specify)	farm, stre			2 No		(Street and		al Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir. completely filled in I		29a. Certifier 17 Certifying Physic (Check only 2 Medical Examin	er: On the basis o	f examination a								
	o the	Medical	29b. Signature at 1 titl. L certify	and manner st	ated.		29c. Lice	ense nun	mber	_	29d. Dat	e signed (Month,	Day, Year)
	FSFO		> your E	dem	V V	m	J)	31	775		APR	128,	2006
	8+1		30. Name and address of person who cor	mpleted cause of o	leath (Item 23a	a) (Type,	Print) 211	レン	BELL	ANV.	CAN	1) 2	1047
100	See the Ct	ate	31. Date filed (Month, Day, Year) 200	6 37 Registr	ar's Signature	A sol	ulis		1	0	- / 1		

		d / Department of Health and MacCertificate of Death	
Physician /Medica	Raymond Frederick Watson		2. Date of Death Month Day 4 2006 12:28a M
Examine	Gilchrist Center for Hospice Car	4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 215-09-8708 6. Sex 1	ast birthday) Yrs. If Under 1 Year ff Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign Country) MD
MAY 4 12,28 AM death with the Maryland me 23e or 28e-f show trives to rediffed at	10a. State 10b. County 10c. City	r, Town or Location arkville	10d. Inside City Limits 1 □ Yes 2 \notin{\text{N}} \text{No}
12,28 17,28 30 0728	10e. Street and Number 9222 Throgmorton Road	10f. Zip Code 21234	10g. Citizen of What Country? USA
336 urs after urs after results by Final	3 M Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	S. 13. Was Decedent of Hispanic Origin? (Spec ff Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☑ No Specify:	offy Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
und 21215-0036 be filed within 72 hours after tal Hygiene. d other then "natural; or ite event, the Medical Example Be Completed by File	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 16b. Kind of Business/Industry
aryland 212: should be filed within nd Mental Hygiene. marked other then marked comp.	17. Father's Name (First, Middle, Last)	Sales 18. Mother's Name Carrie	General Electric (First, Middle, Maiden Sumame) Johnson
Man and 2 s 27 is r trau	19a. Informant's Name/Relationship (Type, Print) Patricia M. Watson - daughter	19b. Mailing Address (Street and Number or Rural 9222 Throgmorton Road,	
mon more pages ent of mt: If it in your or or or or or or or or or or or or or		ace of Disposition (Name of metery, crematory or other place) esapeake Crematory 5/5/	te 20c. Location - City or Town, State
Baltim Permit. Pa Department Important any injury once.	21. Signature of Funeral Sentce Licensee M0098		ohrmann, PA s Drive, Towson, MD 21286
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	on the enter the mode of dying, such as cardiac or the supplies of the supplie	respiratory arrest, Approximate Interval Between Onset and Death Cyloria
58760, Crate be executed physician and sthe burial-transit cideal Examiner	d		
Division of Vital Records, P.O. Box 68760, for Attending Physician: The law requires that the death certificate be explained to attending physician line to the first certificate has been signed by the attending physician line by the funeral director, page 2 should be detached for use as the burial ertification; To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Cords, P w requires that been signed be should be deter		ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
on of Vital Record ding Physician: The law requir h. After this certificate has been s funeral director, page 2 should tlon; To Be Completed			24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
of Vita hysician his certifi Il director	25. Was case referred to medical examiner? 1 Yes 2 Ano Hospital: 1 Inpatient 2 E	26. Place of Death (P/Outpatient 3□ DOA Other: 4□ Nursing Home	
ion of inding Phath. The After this efuneral atton: T			b 5 Residence 6 Souther (Specify) HOSPICE d. Describe how injury occurred
Division c But or Attending P s after death all Director: After t ed in by the funera Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office 28	. Location (Street and Number or Rural Route Number, City or Town, State)
n 24 hou n 24 hou he Funer pletely fill edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowl and manner stated.	ledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To t To t Com	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) May 4 2006
10+1	30. Name and address of person who completed cause of death (frem 2)	(3a) (Type, Print) GEO! N. CHAR	RLES STREET AD ZIZO4
State Registrar	31. Date filed (Month, Day, Year) 2006 Registrar's Signatur		

		•	For State Registrar	State of N	Marylan		artment tificate			and M		giene	06	14276
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of Dea Month	Day 2	Year	3. Time of Death
	/Medic	al	Helen B. Wood 4a. Facility Name (If not institution, give		ər)		4b. City.	Town, or	Location o	of Death	May		2006 unty ol Death	7:50 a ^м
	Examili	(F)	4010 Buckingham H				-	imor					ltimore	9
	Funeral Director		5. Social Security Number 202-30-2698 Usual Residence of Decedent	Sex 7 I□M 2 1 F	Age (In yrs. I	ast birthday) Yrs.	Il Under Months	1 Year Days	II Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day APR 17	1936	9. Birthp Cour	place (State or Foreign htry) PA
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Ba-f et	ctor	MD Baltimo	ore	Ва	l ti mor	:e							1 Yes 2 No
	with th	Funeral Director	10e. Street and Number 4010 Buckingham I	Soad			10f. Zip	Code 2120	7			10g. Citizen	of What Cour	•
	me 23	nera	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13. \	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ	can Indian,
36	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "netural", or iteme 23a or 28a-f ehow event, the Madical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Force 1 Yes 2[If Yes, Give	X No		1 Tes, spec 1 ☐ Yes 2		Specify:	i, Puerio	rican, etc.)		Black, White, ecity:	
00	2 hour		15. Decedent's E		s:	16a. Deced	ient's Usua	I Occupa	ition			16b. Kind o	DJ of Business/In	Lack
215	within 72 lene. than n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4c	or 5+)		kind of wor DO NOT us	k done d e retired,	uring mosi	t of worki	ing		**	·
121	filed wi Hygien ther th		12 17. Father's Name (First, Middle, Last	}		Homen	naker		18 Mothe	r's Name	(First, Middle,		Home	
Maryland 21215-0036	should be f nd Mental b marked of	To Be	James Downing	,					Emm		Claybor		namo)	
lary	2 shou and M ie mar ie mar		19a. Informant's Name/Relationship (Type, Print)			-				al Route Numbe			Code)
e, ⊠	1 and 1 Health em 27 ther tr		Ralph Wood - son 20a. Method of Disposition		20h P						Severn,		21144 on - City or To	num Stato
nor	ages ant of the fit. If ite y or o		1 🗆 Burial 2 🛣 Cremation 3 🗀 4 🗀 Donation 5 🗀 Other (Special			lace of Dispo emetery, cren esapeal							sville,	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic ages.		21. Signature of Funeral Service Lice		M0098						hrmann, Drive,			21286
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Mu	DCAR	diAC	I	nfo	rcti	M				Onset and Death
	/Medical Examiner		Tooling in down,	Due to (or	as a consequ	uence ol):								
	n =	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	ience of).					_			
/	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	ience of):		_						
8760,	e be ex	ical E		d		20.100 0.7.								
9	certificate nding phy use as the		IE EEUWE.	- U										
Вох	eath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Fetal	death 3	Ectopic pre					23d.	Date of delive	e ry Day Year
P.O.	the de y the a	yslc	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant 9□Unknowr		eath 5	Other (spe	9Cify)						
	res that the de signed by the a be detached t	by Pi	Part II. Other significant conditions	contributing to deatl	h but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use	contribute to the	he cause of death?
ord	w require been sig should b									-	101	′es 2□N	o 3 Prob	pably 4 Nnknown
Vital Records,	The tar ate has page 2	Completed				· · · · · · · · · · · · · · · · · · ·					24a. Was autop perfo 1 Yes		prior to co death?	psy findings available impletion of cause of
Vita	Phyaician: T this certifical ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:		ER/Outpatien		Othe	· ·		(Check only o	^	A soist	ed Long
o t	g Phy ter this neral d	 	27. Manner of Death	28a. Date of li		28b. Time of Injury		8c. Injury Work	4 🗆 140		me 5 Resident	-	Oner (Specif	y)
sior	Attending or death. ector: After by the fune	catlo	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n	L N		М	1 🗆 1	′es 2 □ l					
Division	al or Att s after d il Direct od in by	Certification:	4 Homicide determined	28e. Place of	Injury - At ho etc. (Specify		eet, factory	, office			28f. Location (S City or Tox		umber or Rura	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical (29a. Certifier (Check only one) 1 Certifying PI	nysician: To the be miner: On the basis and manner	s of examinat	wledge, death tion and/or ins	occurred avestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the e	cause(s) and date and pla	d manner as s ce, and due to	tated. o the cause(s)
	within To the Comp	W	29b. Signature and title of certifier	& m.d).			License	~ 1-1			7 :	gned (Month,	,
	3		30. Name and address of person who	completed cause of	ol death (Item	23a) (Type,	Print)	R	4, 4	(e4	Burnie	, M.	d., 21	060
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 20	completed cause of	strar's Signa	ture	wells.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician George Leo Werneke, Sr. May 3. 2006 9:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2704 Scarff Road Harford Fallston If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days XXM 2□F 219-22-7746 Yrs. Director 80 Aug. 15, 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "neturel", or items 23s or 28s-f ehow the Middest Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2704 Scarff Road 21047 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter Department of Health and Mental Hyg Important: If item 27 le marked other eny injury or other traumatic event, <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph J. (unk) Werneke Margaret ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Werneke / Wife 2704 Scarff Road, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdns 5-5-06 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . ARTERIOSCLEROTIC CARDIOVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dequaritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown PARKINSONS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 2 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

use as the burial-transit The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-tran P.0. signed to Division of Vital Records, cate has been sig. certificate has funeral director, this Hospital or Attending 124 hours after death. After after death Director: the filled in by To the Hospital within 24 hours a To the Funeral E completely

Maryland 21215-0036

al Hygiene.

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Pages 1 and 2 s ment of Health an

Medical

State

Registrar

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M. ABHYANKAR

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BEL AIR MD 21014

31. Date filed (Month, Day, Year) MAY 0 5 2006

29a. Certifier

(Check only one)

32 pegistrar's Signature

2 NORTH

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 3, **Physician** 2006 9:20 ДМ Patricia Wiser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle River Baltimore 103 Trailway Road 8. Date of Birth (Month, Day, Year) Dec. 29, 1942 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Months 1 M 25F Director 213-40-2415 63 Usuel Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County ir than "natural", or iteme 23a or 28e-f ehow Tre Medical Exeminer must be notified at 1 ☐ Yes 2XXNo Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21220 103 Trailway Road Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if item 27 is marked other there any injury or other treasment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married XIX Married 1 ☐ Yes XX No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Olive T. Smith Andrew J. Hartenhousen ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Trailway Road, Baltimore, Maryland 21220 John Wiser (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2/ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. May 6,2006 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signal - I -uneral Service Licensee ^{22. Name and Address of Eacility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) ances **Physician** Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bone Metastases 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) ierei Director: After th 27. Manner of Death 1, X Natural 2 Accident 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 4 | Homicide afte within 24 hours a To the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Wadical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) We of certifier 29b. Signature and 024356 1 9103 FRANKLIN 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) WATERFIE 0 mo Baltimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 5 2006 Registrar

			1 - For State RegistrarAmend Item	State of Marylan					nd M		iene G. No.	0.5	14279	
П	Physici	an	Decedent's Name (First, Middle, Last, ANNIE PARI			_				Date of Dea Month	h Day	Year	3. Time of Death	
2	/Medic	cal	4a. Fecility Name (If not institution, give			4b. City	. Town, or	Location of	Death	May	4c. Cour	2006 nty of Death	5:15P [™]	_
h	Examin	ier	Stella Maris Hosp				moniu					Balti	more	
	Funeral Director		5. Social Security Number 6. Security Number 10.		last birthday) Yrs.	If Unde Months	Days	If Under 2- Hours	Min.	8. Date of Birth (Month, Day January 1	7,1928	9. Birthp Coun Mary	laca (State or Foreign ltry) land	,
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	r 28a-	rect	Maryalnd Baltimon 10e. Street and Number	e Lt	i chervi		p Code	•		1	0g. Citizen o	of What Coun		_
	th with	aD	8602 Valley Field	Road			21093	3			US	A		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentell by ligner. In internet 23 acr 28	by Funeral Director	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes AIX No If Yes, Give Year or Dates:	1	Was Dec If Yes, sp 1 ☐ Yes		spanic Origi n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No- Rican, etc.)		ace - Americ lack, White, cify: W		
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121	within the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	_{ро мот} Teac	use retired)			D-1+	imono	County	
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Maryland 21215-0036	should be t and Mentel I s marked o umatic eve	To Be	Thomas Parran Sr	rna Print)	19h Maili	ng Addres	e (Street			ne Bond	City or Toy	vn State Zin	Code	_
	nd 2 s lith an 27 is r r traus	ľ	19a. Informant's Name/Relationship (T) Warren H Eagner	Husband		•	,						and 21093	
Baltimore,	of Head		20a. Method of Disposition 1 ☐ Burial AN Cremation 3 ☐ F	20b. F	Place of Dispo	sition (Na matory or	me of other place	e)	D	ate	20c. Locatio	n - City or To	wn, State	_
Ĕ	Pages ment of I ant: if it		4 ☐ Donation 5 ☐ Other (Specify)	Gre	enMour			1	3/3/0)6	Balti	more,	Maryland	
Ball	Departic Departic Importa any inju		21 Signature of Funeral Strvice Licens	Kenak	22	2. Name a	and Addres	s of Facility 6500	LITT	chell-Wie Road Balt			Home Inc. d 21212	
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consequence)	uence of):	/	lisa			2 X			Approximate Interval Between Onset and Death	
ထာ	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	quence of):									
.O. Box 6	The law requires thet the death certifica Ite has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Sto	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	aldeath 3[∃Ectopic ∃ Other (s	pregnancy specify)				1	Date of delive	ery Day Year	
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/ita	Attending Physician: The Ir death. c death. ector: After this certificate haby the funeral director, page	Be (25. Was case referred to medical examiner?	formital:	7112		1 04			Check only or				_
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	10		30. Name and address of person who co											-
			EDDIE NAKHUDA, M 31. Date filed (Month, Day, Year)	.D. 2300 DUL		ALLE	Y ROA	D TII	MONI	UM, MD	21093			
	Sta Registi		MAY 0 5 20			E N								

DHMH 17 Rev 1/2001

MAY

ANNIE WAGNER

06-02953

William Sterling Wett

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		For State		Certifica	ate of	Death			Re	g No -	110	14200
Physician fledical Examine	1	. Decedent's Name (First, Middle WILLIAM	STERLING WETT stion, give street and number) 4b. City, Town, or Location of						Date of Deat Month May 1, 200	Day Ye	ar	3. Time of Death 2214 hrs
	4	a. Facility Name (if not institution Carroll Hospital Cente			4			f Death		4c. County Carroll	of Death	
Funeral Director		214-80-5178	6. Sex 7. Age (I	n yrs. last birt 45		If Under 1 Year Months Day		r 24Hrs. Min.	8. Date of Birt	1960	Foreign	hplace (State or n untry) MD
daryland 28a-f show any <u>d at once.</u>	1	Usual Residence of Decedent Oa State MD CAF	RROLL 10	c. City, Town	or Locatio	FINK	SBURG					10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		Oe. Street and Number 3256 SYKESVILI	LE ROAD			10f. Zip Code 21	048		10	0g. Citizen of W	hat Coun	
fter death wi !", or items ter must be			arried 12. Was Decedent Ev Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		If Ye	Decedent of Hiss, specify Cubar	n, Mexican,			Whit	e - Amerio e, etc. WHIT	can Indian, Black,
36 nin 72 hours a than "natural dical Examin	nanaidillo	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12			during ma	s Usual Occupa st of working life ERAL LA	e. DO NOT			16b. Kind of B		ndustry BOR
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiens item 27; is marked other than item 27; is marked other than 17 and 17 an	֓֞֞֞֜֞֜֞֜֓֓֓֓֓֓֓֓֓֟֟֜֟֓֓֓֓֓֟֟֓֓֓֓֟֟֜֟֓֓֓֟֟֓֓֓֟֜֟֓֓֟֟֓֓֟֟֓֓֟֟	7. Father's Name (First, Middle, ROLAND	J.		W	ETT	18 Mother's	CATHY		Maiden Surname	e) (HE	IMINIAK)
MD 27 nd 2 should alth and Me m 27 is ms rm 27 is ms TO	2 1	9a. Informant's Name/Relations ROLAND WETT/E			5499	Address (Stre	ST DR	IVE	SEMI	NOLE, F	ΊΔ	33772
MOF Pages nent of ant: If		Oa. Method of Disposition Burial 2 Cremation Donation 5 Other S	n 3 Removal from State	cremat	ory or oth	MATORY		5-4-	Date -2006	20c. Location	VILL	E, MD
Balti permit Departn Importi injury	2	21. Signal re of Fune al ervice	licensee	1211 CHESACO AV						DALE FU SEDALE,	NERA MD	L HOME 21237
Physician /Medical Examiner	J	23a. Part. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	a. Alcohol, cocaine and hydromorphone intoxication							est, shock, or he	eart	Approximate Interval Between Onset and Death
Ladillilei	П	or condition resulting in death) Sequentially list conditions,	Due to (or as a consequent)	ience of):								
ted Insit	aminer	If any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence									
760, icate be executed sphysician and the burial - transit		X UNPENDED	d. AMENDED item	#23a.27.	.28a-f	nerME.ø8	355.5/2 ₄	4/06 T	T		<u></u>	
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∞ ∄ ≝ a		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	23c. If yes, outcome 1 Live birth 4 Pregnant at tin known 9 Unknown		2 Fet	al death 3 ner (Specify)	Ectopic	pregnanc	Ç y	23d. Date of Month		y Day Year
, P.O. Box 6 res that the death cer signed by the attend be detached for use		Part II. Other significant condit	tions contributing to death b	ut not resultin	g in the u	nderlying cause	given in Pa	art I.	11	_		the cause of death?
Division of Vital Records, P at or Attending Physician: The law requires t is after cleath. al Director: After this certificate has been sign led in by the funeral director, page 2 should be to the control of the co	Completed by		<u>.</u>						24a Was autop perfo 1 Yes	rmed?		topsy findings available completion of cause of
Triffic tor, p		25. Was case referred to medica	ai			26.Plac	e of Death	(Check or	ily one)	1		
Vita ysicia his ce direc	o Re	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/C	utpatient	3 DOA	Other ₄	Nursing	Home 5	Residence 6	Other	
of of grand filer the neral	- t-	27. Manner of Death	28a. Date of Injury (Month, Day,Yea		Time of Ir	njury 28c. Inj	ury at Work	? 2	8d. Describe	how injury occu	rred	_
Ision of Vital Rec Attending Physician: The rr death. ector: After this certificate by the funeral director, page	<u> </u>	1 Natural 5 Pen			1 9:39	PM 1	Yes 2XXX	No U	ınk			
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To the Hosp within 24 ho To the Fune completely f	न		Physician: To the best of my kaminer: On the basis of examinand manner stated.			ion, in my apinio	on, death oc					
- 3 - 0	Ĕ	29b Signature and title of certific	er				nse number					nth, Day, Year)
	-	30. Name and address of person	Me The A	th (Item 23a)		0.0	.M.E.			May 2, 20	06	
1		Theodore King MD.	Assistant Medical Ex		111 Pe	nn Street, B	altimore,	MD 21	201			
	State 31. Date filed (Month, Day, Year) 82. Registrar's Signature egistrar 840 Y () 5 2006											
	_	111111 0 - 10		-								

			For State Registrar	State of M		d / Depa		t of H	ealth a				-	1 28
			1. Decedent's Name (First, Middle, Last	•							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Irvin Daniel Wall	ls, Jr.							May 1,			11:30A M
)	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	f Death		4c. (County of Deat	th
			4300 Cardwell Ave										altimor	
	Funeral Director		5. Social Security Number 206-07-2509 6. Se	x 7. A	ge (In yrs. i	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Sept.]	Year)	9. Bird Co 1918 P	hplace (State or Foreign buntry) A
	/land		10a. State 10b County imo	re	10c. City	y, Town or Lo	cation	····						10d. Inside City Limits
	Man	tor	Maryland County		_									1 ☐ Yes 2 💢 No
	n 128	irec	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What Co	ountry?
	23a c	aiD	4300 Cardwell Ave.	, Apt 12	8		21	.236				U.S.	.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at anote.	by Funeral Director	11. Marital Status 1 Never Married Amarried 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 14 Yes 2 ☐ If Yes, Give Year or Dates:	?	S. 13. 1	Was Deced f Yes, spec 1 Yes	dent of Hi cify Cuba XX 2 No	spanic Orig n, Mexican, Specify:	in? (Spec , Puerto R	cify Yes or No- lican, etc.)		4. Race - Ame Black, Whit Specify:	
ŏ	2 hou	Completed	15. Decedent's Edu	cation		16a. Deced	dent's Usua	al Occupa	ition			16b. Kin	d of Business	Industry
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Baltimore,	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1		, ,	lace of Dispo emetery, cren laney				_{Da} 05 ~ 0			ation - City or	
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ita	clan: ertific ector.	Be (25. Was case referred to medical examiner?							of Death	Check only on	0		-
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Ž	or At fter d Direct in by	Certification:	4 Homicide determined	28e. Place of In building, e	iury - At ho tc. (Specify		eet, factory	, office		28	Bf. Location (St City or Town		Number or Ru	ıral Route Number,
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	withir To th	×	29b. Signature and title of certifier				290	. License	number		2	9d. Date	signed (Monti	h. Day, Year)
	,		> > lowstell	42				000	3536	3		5	13/06	
1.	11		30. Name and address of person who co	empleted cause of	death (Item	23a) (Type.	Print)	- •				/	1	6
V	7		Sandra Mars 1 31. Date filed (Month, Day, Year)	nallus	Ba	Unner	e VA	Me	3536 dicd	- Cer	ter	101	1. Green	eSt. Baltmo
	Sta Registr		MAY 0 5 200	A2. Regist	s Signa	No.								MD

			1 - For State Registrar	State of Maryland		artment of H			giene Beg. No.	4282
***	Physici		1. Decedent's Name (First, Middle, Las	ten				2. Date of De. Month	Day Year	3. Time of Death 4:40 PM
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	r Location of Deat	-	4c. County of Death	1
			MERCY MOSPIT			Baltime		anyland	N/A	
	Funeral Director		5. Social Security Number 6. S 215-04-2011 Usual Residence of Decedent	ex 7. Age (In yrs. I	/ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. State of Bird (Month, Da	y, Yafar) 9. Birth	place (State or Foreign Intry) LNA
	Maryland -f show	tor	10a. State 10b. County	re County Tows	r, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3e or 28a It be notifi	Funeral Director	10e. Street and Number 6 Malibu Court			10f. Zip Code 21204		Ţ	10g. Citizen of What Cou Jnited State	•
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23e or 28e-f ahow or other traumatic event, the Medical Expolmer count be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Amer Black, White Specify: Chi	, etc.
Maryland 21215-0036	within 72 hou ene. than "nature ite Mudical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done o DO NOT use retired LEnginee	during most of wo d)	rking	16b. Kind of Business/li Engineerin	·
land 5	ild be filed tental Hygie ked other	To Be Co	17. Father's Name (First, Middle, Last, Gon-Shu				18. Mother's Na Shun-Yin		Maiden Sumame)	
	is 1 and 2 should be for the alth and Mental I fem 27 is marked or other traumatic eve		19a. Informant's Name/Relationship (Ms. Sissi W. Gec)	The state of the s		-			er, City or Town, State, Zi .ls Maryland	
Baltimore,	Pages 1 a nent of Hei int: If Item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	IRemoval from State EVa	lace of Dispo emetery, crer ans Fu	esition (Name of matory or other place neral Cha	pel May	Date 1, 2006	20c. Location - City or T Forest Hill	own, State , Maryland
Balti	permit. Pages. Department of H Important: If Ite eny injury or of		21. Signature of Funeral Service Licer		Pe	2. Name and Addres	ss of Facility Iternati	ves Fune	eral&Cremati Maryland, 21	on Ctr.P.A.
-07	Physician		23a. Part . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		er the mode of dyin	ig, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
5	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ						
Ţ.	outed of ansit	Examiner	Sequentially list conditions, tary leading to in red a cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a cons	vence of):					
8760,	ate be executed thysicien and the burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):					
Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delin Month	very Day Year
ds, P.O.	lew requires that the de as been signed by the a 2 should be detached t	ρ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Vital Records,	0 - 0	Completed						24a. Was autor perfo 1 Yes		opsy findings available ompletion of cause of
/ita	sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?					ath (Check only o		
d	Physician: this certific ral director,	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatier		4 🗀 Nursing i		dence 6 Other (Spec	ify)
OU	ding h. After tune	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	Wor	k? Yes 2 □No	20d. Describe	now injury occurred	
Division	4 5 5 5	ertification:	3 Suicide 4 Homicide 6 Could not be determined	e 29a Place of Injury - At ho		reet, factory, office		28f. Location (City or Tou	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirtecompletely filled in	edical C		nysician: To the best of my kno niner: On the basis of examina and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	12.00		29c. Licens	e number		29d. Date signed (Month	, Dey, Year)
,	4		yans Bu	ellil		AU417	6435B 15	845	April, 23"	2006
-	ν '		YANIS BE	completed cause of death (Item	23a) (Type,	Print)	+, Balti	more, He	29d. Date signed (Month April, 23rd angland 21	201
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. registrar's Signa	ture.	CONF			٧	

06-02856 Joseph Young

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1705 hrs Joseph Young Medical Examiner April 27, 2006 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) c. County of Death Randalistown Northwest Hospital **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Min Director 62 12 20 43 MD 1 X M 2 Country) 212-42-5690 Usual Residence of Decedent 10a. State Oc. City, Town or Location 10d. Inside City Limits Reisterstown 1 Yes 2XXNo 28a-f show Baltimore Owings Mills MD hours after death with the Maryland rector s 23a or 28a-f e notified at o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ā 14 Brookberry Drive Apt Al 21117 21136 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No 1 Yes Black Widowed 4 Divorced If Yes, Give Year Yes X No specify: Specify. ð 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hot Department of Health and Mental Hygiene Important: If frem 27 is marked to the Medical East injury or other transmatic event. the Medical East during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Drive Trucking Co. 12th grade na 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Issac Young Irene Powell 21136 19b. Mailing Address (Street and Number or Rural Route Number Street Street Street And Number or Rural Route Number Street Stree 19a. Informant's Name/Relationship (Type, Print) Sallie Young-Wife 14 Brookberry Drive, Apt Al, Owings Mills 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X 8urial 2 Cremation 3 Removal from State Zion 5/6/06 Mt. Baltimore, Md Donation 5 Other Specify: 22. Name and Address of Facility
March F/H West Signature of Funeral Service License 4300 Wabash Ave, 21215 Baltimore, Md disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Retween Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED X AMENDED#10c&f&19b Per FH G855 5/05/06 JH the attending physician ed for use as the burial Division of Vital Records, P.O. Box 68760, 24 hoursailer death certificate be 24 hours after death

25 hours after death

26 funeral Director: After this certificate has been signed by the attending physicietely filled in by the funeral director, page 2 should be detached for use as the burietely filled in by the funeral director, page 2 should be detached for use as the burietely filled in by the funeral director, page 2 should be detached for use as the burietely filled in by the funeral director, page 2 should be detached for use as the burietely filled in by the funeral director, page 2 should be detached for use as the burietely filled in by the funeral director. IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Fetal death Month Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ficate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Nursing Home 5 Residence 6 ٩ 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) To the Hospital o within 24 hours af To the Funeral D determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d Date signed (Month, Day, Year) 29b Signature and title of certifier O.C.M.E. April 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0

strar's Signature

2006

			1 - State Amend #11,18	State 8	of Maryla er Inf	nd / De G857	partmer //26/0	t of H	ealth a	and Me	ntal Hy	giene Reg. No.	2006	14284	
4	967.	~	Decedent's Name (First, Middle, La								Date of Dea	ath		3. Time of Death	
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	Funeral		5. Social Security Number 6.	Sex 1 □ M 2 X □ F	7. Age (In yr	s. last birthda	Months	r 1 Year Days	If Under Hours	24 Hrs. 8 Min.	Date of Birt (Month, Day		9. Birtl	hplace (State or Foreign untry)	
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	th the	irec	10e. Street and Number				10f. Zi	o Code	··			10g. Citi	zen of What Co	untry?	
	23a c	ral	6111 Montrose Ro					852_						States	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Itame 23e or 28e-f show any injury or other traumatic avant, the Madical Entitle mainte and liked at once.	by Funeral Director	11. Marital Status 1 Never Married 3 Wildowed 4 Divorced	Armed 8	2 XNo Sive	U.S. 1	3. Was Dece If Yes, spe 1 \(\subseteq Yes		ispanic Ori in, Mexicar Specify:		fy Yes or No- can, etc.)		14. Race - Ame Black, White Specify:		
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re, M	f Healt fem 2 tem 2		Frona Adelson (D. 20a. Method of Disposition		20b	. Place of Dis	sposition (Na crematory or	me of		Dat			cation - City or		
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			30. Name and address of person who Shilpa Amin 61					م MD	2085	52					
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		•	For State Registrar	Oldio or ivi	aryland / De <i>C</i>	ertificate of			Reg. No	UUU	14200
			Decedent's Name (First, Middle, La.	st)			- 1	2. Date of D	Death		3. Time of Death
	ıysici: Medic		Josephine Mary	Alvarez				April	Da 8	y Year 2006	9:05 AM
	kamin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of D	eath	4c	. County of Death	
			Garrett Memorial	Hospital		0akla	nd			Garrett	
	neral		Social Security Number 6. S	ex 7. Ag	e (In yrs. last birtho	Months Dave		Ain. (Month, L	Day, Year)	9. Birth	place (State or Foreign ntry)
Dire	ctor		234-54-1635 Usual Residence of Decedent	- X	89 Yrs	3.		Jan 1	9 191	7 WV	
land	22	1	10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
Mary -feh	pall	tō	WV Harris	on	Clark	ehura					1 ☐ Yes 2 🙀 No
the 728e	DOI:	Director	10e. Street and Number	<u>on</u>	Olaik	10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
with a sa o	at be		Rt. 3 Box 103			2630	1		T	Inited St	ates
deatl	TIES .	Funerai	11. Marital Status	12. Was Decedent 1 Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		? (Specify Yes or N		14. Race - Ameri	can Indian,
Z15-UU36 thin 72 hours after death with the Maryland e. en "natural", or Itema 23a or 28e-f ehow	adical Examiner must be notified at	by Fu	1X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2XIII	lo	1 X Yes 2 No		ueno Hican, etc.)		Black, White, Specify: Whit	
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			Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		cemetery,	crematory or other pla					
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B e e	any		Iloned A. Y	Sundeck		22. Name and Address	Second	Surdock-D Street,	urst Oakl	Funeral and MD	Home 21550
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Physici		Decedent's Name (First, Middle RICHARD TILG)		SR.					2. Date of Dea Month APRIL	th Day 20	Year 2006	3. Time of Death 4:15PM M
/Medic Examin		4a. Facility Name (If not institution			4b. City, To	wn, or l	Location of	f Death	ALKII		unty of Death	4.13IH
		108 WEST MAPI	E ST.				ICHAE				TALBO	T
Funeral Director		5. Social Security Number 220–28–0539	6. Sex 1 ▼ M 2 ☐ F	Age (In yrs. last birthday 73 Yrs.		ear Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth	Ť932	Coun	ace (State or Foreign try) YLAND
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10	Od. Inside City Limits
Mary efsh	ţ	MD TAL	вот	ST. M	ICHAELS	:						1XYes 2□No
deeth with the Maryland ms 23a or 28e-f show fromst be notified at	Director	10e. Street and Number	****		10f. Zip Co	ode			1	0g. Citizen	of What Coun	try?
ath w		108 WEST MAP					1663					SA
ē # #	by Funeral	11, Marital Status 1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	□No	Was Deceden If Yes, specify 1 Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - America Black, White, e Becify:	
Z15-UU36 thin 72 hours aft e. an "naturel", or Meulon Exern			t's Education	16a, Deci	edent's Usual C	occupat	tion		i	16b. Kind o	of Business/Inc	
Z1Z15-U Jene. Ir then "nature of the office	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4c	or 5+) life.	e kind of work of DO NOT use i	retired)	-		ng			
200		10 17. Father's Name (First, Middle,	(act)	EQU	IPMENT				(First A4144)		AVATING	-
ld be ental kad c	o Be	TILGHMAN H.	,						(First, Middle, Y WATTS	Maiden Sur	name)	
Maryla d 2 should th and Men th and Men traumatic		19a. Informant's Name/Relations	hip (Type, Print)	19b. Mail	ing Address (S	treet a	nd Numbei	r or Rura	l Route Number	, City or To	wn, State, Zip	Code)
C = 01 L		ANN D. BALL/W	IFE				E ST	- 33	r. MICH			
		20a. Method of Disposition 1X Burial 2 ☐ Cremation			matory or other	r place			ate		on - City or To	
Baltimo permit. Page Department of Importent: If any Injury or		* 4 □ Donation 5 □ Other (S		WOODLAW	2. Name and A				23/2006	LAS.	CON, MA	KYLAND
Departition of the poorting of		FUGHN F	. MERC	ERON P	ELLOWS, OO S. E	HE LARR	LFENI LISON	BEIN ST.	& NEWN. EASTO	N, MD	NERAL H 21601	OME PA
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Meta		sopher	of dying	, such as d	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
. BOX b8 / b0, death certificate be executed e attending physicien and of or use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
5	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregi □ Other (s <i>peci</i>					23d.	Date of delive Month	ry Day Year
KECOTGS, F ne law requires that s has been signed b	þ	Part II. Other significant conditi	ons contributing to death	n but not resulting in the	underlying caus	se giver	n in Part I.		23e. Did to			e cause of death? ably 4 Unknown
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UIVISION iel or Attending s after death. il Director: Afte ad in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be ined 28e. Place of building,	Injury · At home, farm, s etc. (Specify)	treet, factory, o	ffice		4	28f. Location (SI City or Town		ımber or Rural	Route Number,
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai (29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the be Examiner: On the basis and manner	st of my knowledge, dea s of examination and/or in stated.	th occurred at the action of t	the time my opi	e, date and inion, deatl	place, a	and due to the co	ause(s) and ate and pla	I manner as sta ce, and due to	ated. the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifie	r		29c. L	icense	number	21/	2	11	gned (Month, L	Day, Year)
0+114		30. Name and address of pe	o completed cause o	of death (Item 23a) (Type	, Print)	-	16	ulo.	MO 71	60/	1106	
Sta Regístr		31. Date filed (MAPR 2 4	2006 Regi	strar's Signature			a3/1 0			00/		

		For Stete Registrar	State of Ma	ryland / Depa <i>Cer</i>	tificate of I		Re	g. No.	14287	
Dhusia		Decedent's Name (First, Middle, Last)					2. Date of Death Month	n Day Year	3. Time of Death	
Physici /Medic		Amelia	L. Be	enson			04	5 2006	10 50P	
Examir		4a. Facility Name (If not institution, give s	treet and number)		Location of Death		4c. County of Death			
		Mallard Bay Ca			Cambri			Dorche		
Funeral		5. Social Security Number 6. Sex	M WE	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreig untry)	
Director		220 20 1790	9	5 Yrs.			12 07	1910 Ma:	ryland	
pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limit	
anyla sho	۲								1X Yes 2 □ N	
M 9c 1.88 1.	Director				10f. Zip Code		10	og. Citizen of What Co	untry?	
vith ti	DI	10e. Street and Number	- Chwoot	21601				U.S.A.	,	
ath v	ral	40 South Locust	2. Was Decedent E	vor in II C 12 1		lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian.	
s within 72 hours after death with the Maryland jiene. Jiene, rethen "neturel", or Items 23e or 28e-1 show Ite Madical Exaculturel and the matter matter and the matter and	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify: B1	e, etc.	
hour	d be	15. Decedent's Educ		*				16b. Kind of Business		
ad within 72 hours aff giene. er then "neturel", or i, tre Medical Exama	Completed	(Specify only highest grade	completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			ring			
within ene. then "	mc	Elementary/Secondary (0-12)	College (1-4or 5+		try Wor			Food		
G 5, 6		10 17. Father's Name (First, Middle, Last)					e (First, Middle, M	Maiden Sumame)		
ed is a second	To Be	George Rasin				(Carrie	Thomas		
nd 2 should be file lth and Mental Hy 27 is marked oth treumetic event	F	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)	
d 2 si th ar treu		Claudine Blake	e (daugh	ter) Ho	pkin's	Place 1	Easton,	Maryland	1 21601	
s 1 and 2 should f Health and Men item 27 is marke other treumetic		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or		
Pages ment o ent: If ury or		ty Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)		Woodlaw	n Mem.	Pk. 4/2				
permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service License	shell	S		322 Eas		Dashiell Easton,		
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line	the death. Do not ent e.	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
Pnysician		Immediate Cause (Final disease or condition	end s		11)4000					
/Medical		resulting in death)	Due to (or as a	considence of):					, , ,	
Examiner		Conventially list conditions	lung		1 year					
	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
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an a										
ficate be ex physician is the buria	edical		1							
- m a		IF FEMALE:		700.00						
The law requires that the death certification is the has been signed by the attending lage 2 should be detached for use as	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death 3 [Ectopic pregnancy	у		23d. Date of de Month	livery Day Year	
ie death the atte	sicia	Physician/M	1 ☐ Yes 2 ☑ No	4☐Pregnant at t 9☐Unknown	time of death 5	Other (specify)				
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ding Ph After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	of 28c. Injui	ry at rk?	28d. Describe ho	ow injury occurred		
d or Attending after death. Director: After din by the fune	atlo	2 Accident investigation			M 1	Yes 2□No				
Arte ecto	tific	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or R n. State)	ural Route Number,	
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To the I within 2 To the Complet	Me	29b. Signature and title of certifier		1	29c. Licens	se number	2	9d. Date signed (Mgh	th, Day, Year)	
- s - o		A Chan	su X	340	H	5997	3	4/19/0	6	
		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type	Print)	imbria		2		
		P. Lahnson	100 BY	an blis	st Ca	mbrid	geML			
9 30	210	31. Date filed (Month, Day, Year)	32 angistra	r's Signature			1			
S	tate	31. Date filed (Month, Day, Year)	32 agistra	rs Signature	2 0					

DHMH 17 Rev 1/2001

Amend Item 29d per Dr., G855, 05/05/06dhb.

Red, No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician 1:20 A. M Tony Burlot 23, Ray 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Days | Hours | Min. F e b • 27 , 197 | Maryland 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Yrs. 212-08-6815 35 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show traumatic event, the Medical Examiner must be notified at MD Harford Aberdeen 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21001 720 Paradise Road Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXDNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innent of Health and Mental innt: If item 27 is marked o Armand Michel Burlot Wanda Grace Petty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Armand M. Burlot (Father) 720 Paradise Rd. Aberdeen, Maryland 21001 Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/06 Bel Air, Maryland Bel Air Mem. Gdns. any injury o * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses ²². Name and Address of Facility Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001–3399 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Preumone a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ceme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 14 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Linatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the April 23, 2006 3 . Tiame and address of person who completed cause of deat 1 (tem 23a) (Type, Print) 22. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 5 2008 Registrar

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	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland content of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Modical Examination and item of items.	Funeral Director	13023 Ingleside I	rive		10f. Zip Code	20705	1	Og. Citizen of What Co United St	•
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certifier	and manner state		29c. Licensi			≥9d. Date signed (Mon	
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	8		30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type	Print)			07/18	100
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		ate	31. Date filed (Month, Day, Year)	32. Register	s Signature	Caste	7. 2.			
	Regist	rar	APR 21	2006	UN A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Day 18, 2006 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year **Physician** 11:45 AM April Frances D. Barfoot /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton 1653 Fendall Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 20, 1910 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days New York 1□M 2XF 95 Director 111-16-5417 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or iteme 23a or 28a-f show treumatic event, the Medical Experiment must be notified at 1 XYes 2 No Directo Anne Arundel Crofton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1653 Fendall Court 21114 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: White Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hotel Payroll Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Rose Light Charles Demane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 1653 Fendall Court Crofton, MD 21114 Herbert Barfoot / Husband other 20b. Place of Disposition (Name of comptery, cumatory or other place)
MaryLand 20a. Method of Disposition 20c. Location - City or Town, State Department of h Importent: if its eny injury or of once. 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 04/24/2006 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5418 Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital Hospital or Attending Physicien: After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√0 Certification: To Division of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funerei Director; completely filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29d. Date signed wonth, ay, Year) 29b. Signature and title of certifig 30. Name and address a cerson who of pleted cause of death, tem 23a) (Type, frint)

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2006

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. Registrar's Signature

Richard John Bonham

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event. <u>Il</u>	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility		Upper Deer	
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Div pital o ours af filled i	Certification:	4 Homicide determined (Specify) Drainage ditch	or Town, St. Marydel.	ate) 26982 MAry MD	del Rd.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated			
F > F 5	Me	29b. Signature and title of certifier 29c License number		29d. Date signed (M	onth, Day, Year)
		Carol Hallow O.C.M.E.		April 25, 2006	
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
S Regis	tate trar	31. Date filed (Manth, Day Year) 2006 32 kegistrar's Signature			
DHMH 17 Rev 1/2		ORIGINAL			

## E. Equity Name of the Architors, piles steel and number) 9159 BLACK DOG ALLEY 10 Supplement of Decades 10 Supplement	Physician	1	For TCHD, 04/20/2006 State TCHD 04/20/06 Decedent's Name (First, Middle, L GARY COOPER,	.ast)					2. Date of Dea Month APRIL	Day	2006	3. Time of Death 9:30PM
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1_Separate 2_Cremation 3_Removal from State WOODLAWN MEMORIAL PARK 4/18/2006 EASTON, MARYLAND	I Direct	1		AT T EV		10f. 2	·	Λ1				try?
SAMUEL BELL COOPER SAMUEL	d by Funera	1	1. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.S. No	1	cedent of His pecify Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. F	Race - America Black, White, e	etc.
SAMUEL BELL COOPER 18th Mother's Name (rist, Modele, Last) 18th Mother's Name (rist, Modele, Last) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19th Mailing Addres	mplete		(Specify only highest g	rade completed)		(Give kind of v life. DO NOT	work done du Luse retired)	tion uring most of wo	rking			·
19a. Informants Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	Be	ם ו				OWNI				Maiden Sun		ING
1-Beurial 2 Cremation 3 Removal from State VOODLAWN MEMORIAL PARK 4/18/2006 EASTON, MARYLAND												Code)
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interest the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interest the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interest the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interest the disease, or complications conditions content as a consequence of line.		2	Oa. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place o	of Disposition (N ery, crematory of	Name of or other place)	Date	20c. Location	on - City or To	
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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Ins certificate has been signed by the attending prystolar and in properties at the burial-transit in properties at the burial-transit in properties at the burial-transit in properties at the burial-transit in properties at the burial-transit in properties at the burial-transit in properties at the		23a. Part1. Enter the disease, or conshock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No Yes mplications that caused by one cause on each line a. Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due	a consequence a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting and 2 ER/O Ty Year) of my knowledg examination an	poof): h 3 Ectopic 5 Other (in the underlying of Injury M arm, street, factor on the course of the course on the course of the course on the course of the course on the course of the course on the course of the course on the course on the course of the course on the course on the course on the course of the course on the course of the	pregnancy (specify) 28c. Injury Work? 1 Years on, in my opi	n in Part I. 26. Place of Dea 4 Nursing Feat	23e. Did to 1 Yes autoperform 1 Yes autoperform 28d. Describe he 28f. Location (S. City or Town) and due to the curred at the time, described and	est, 23d. 23d. 23d. 23d. 24 No 24 No 22 No 22 No 24 No 24 No 24 No 25 No 26 No 27 No 28 No 29 No 29 No 20 No 20 No 20 No 20 No 21 No 22 No 23 No 24 No 24 No 25 No 26 No 26 No 27 No 28 No 29 No 20 No	Date of delivered Month in the contribute to contribute to the contribute to contribute to the contribute to contribute to the contribute to contribute to the contribute to t	Approximate Interval Between Onset and Death y Day Year e cause of death libly 4 Unkno sy findings availa lipletion of cause 22 No Route Number, lited. the cause(s)	

			1- State Registrar Amend Items State 26 per III)			Alth and Market No.	-	_	6 14293
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physici		Richard James	Cr	utchley		Month April	14 200	6 1210 ^M
	/Medio		4a. Facility Name (If not institution, give street and number)			Location of Death	прили	4c. County of	
	Examir	ier	Anne Arundel Medical Center		Annapo1:			Anne	Arunde1
			5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	3/17/52	B. Birthplace (State or Foreign Country) Maryland
	Funeral Director		10X M 2□ F	Yrs.	Months Days	Hours Min.	(Month, Day	, Year) 7 1052	Maryland
	Director		217-58-4300 July 194	1			Hazen	, ,	.nai y i and
	land		10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limits
	Mary -f sh lied	ō	MD Anne Arundel A	nnapo	lis				1 □ Yes 2 No
	28e	rec	10e. Street and Number		10f. Zip Code			l0g. Citizen of Wh	at Country?
	burs after death with the Marylan rel', or Items 23e or 28e-f show	٥	197 Severn Drive		21	401		USA	
	leath	era	11 Marital Status 12. Was Decedent Ever in U.S.	13. V		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		- American Indian,
	fer of free free free free free free fre	Fun	Armed Forces? 1 □ Never Married 2X Married 1 □ Yes 2 X No				Rican, etc.)		White, etc.
35	Is a	þ	3 ☐ Widowed 4 ☐ Divorced	1	☐ Yes 2 No	Specify:		Specify:	White
5	72 hours "naturel",	ted		I6a. Deced	ent's Usual Dccup	ation	:	16b. Kind of Busi	ness/Industry
7.	within 72 ho piene. r than "natur ine Medical	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	during most of work i)	ing		
21215-0036	IL Z 12.15-0050 filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Items 23s or 28e-f show ent, the Madica Exactic ef must be notified at	Completed by Funeral Director	10 A	utobo	dy Mecha	nic		Automot	ive
7	e filed other vent, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Sumame)	1
<u>- 6</u>	Menta Menta rked fice	2	Louis Vincent Crutchley			Bertha A	nne Kil	lenbenz	
	partificate, interpretation permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If item 27 Is marked other any injury or other treumatic event, once.	ŀ.	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Numbe	r, City or Town, St	tate, Zip Code)
	alth a		Pamela L. Crutchley (Wife)	197 S	evern Dr	ive, Anna			
\$	of He		com	e of Dispo- etery, cren	sition (Name of natory or other plac		Date	20c. Location - C	ity or Town, State
i i	Page lent c nt: If ry or		12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	crest	Cemeter	у 4-20	-2006	Annapoli:	s, MD
	mit.		21. Signature of Euneral Service Licensee	22	Name and Address	ss of Facility Funeral	Home P	Δ	
à	Depa Depa Impo any is		Tatal 2 Ms			ly Avenue			21401
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Ů,	e as	Me	IF FEMALE:						
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	the a	sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of deat	h 5∟	Other (specify)				
3 3	that the delached by the s	Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the u	aderlying cause gry	en in Part I	23e. Did to	bacco use contrib	oute to the cause of death?
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70	KECOFQ	nple					24a. Was autop	sy pri	ere autopsy findings available for to completion of cause of eath?
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0	OT VITAL Physicien: The This certificate ral director, pag	Be	25. Was case referred to medical examiner?		046	26. Place of Deat	h (Check only o	ne)	
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4	ISIO ktendi death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No	204 111 /6	Na	and Drived Davids Misselfon
4	DIVISION Hospitel or Attending 24 hours after death. Funerel Director: After	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, tarm, str	eet, factory, office		City or Tow	m, State)	r or Rural Route Number,
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	Hosp 4 ho Fune fely fi	ledical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	eage, death n and/or in	restigation, in my o	me, date and piace, ppinion, death occur	red at the time,	tate and place, an	nd due to the cause(s)
	To the within 2 To the complete	Med	one) and painer stated. 29b. Signature and title of certifier	7 a N	29c. Licens	e number		29d. Date signed	(Month, Day, Year)
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			, which were	W7	Print) 1 - 2	7 (N) K	1)	710	or Grana MD
			30, Name and address of person with completed cause of death them?	7"	MAA	DIC VI	1)110	Pet	er Graze MD
	C+	ate	31. Date filled (Month, Day, Year) (32. Registrar's Signatur	е	11 10 0 14 0	,01		()	
	Regist		APR 2 0 200b	A					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) Month Day 12:30 AM Alija Colic APRIL 19, 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Prince George's 8017 Mandan Road Greenbelt | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUN 7, 1945 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**∑**M 2□F Yrs. 227-83-5249 60 Bosnia Usual Residence of Decedent IOd. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 8017 Mandan Road 20770 Bosnia 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Machine Operator Production 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Colic Sbrecakovic Hajro Emina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7810 Hanover Pkwy, #T-3, Greenbelt, MD 20770 Edin Colic / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/21/2006 Laurel, Maryland MD National M.P. * 4 ☐ Donation 5 ☐ Other (Specify) Thibadeau Mortuary Service, P.A. 933 Gist Av.LL, Silver Spring, MD 20910 21. Signature of Funeral Service Lic M00956 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinoma Of Brain Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Dua to (or as a consequence of):

Physician /Medical Examiner

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Physician

/Medical

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10a. State

Funeral

Director

or Items 23a or 28a-f show

the Medical Examiner must be nutified at

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Funeral

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Completed

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Il Hygiene.

mit. Pages 1 and 2 should be filed w partment of Health and Mental Hygier portant: If tem 27 is markad other the y rinjury or other freumatic event, the

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	g cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ★ Unknown
				24a. Was an autopsy performed 1 ☐ Yes 2 ∰	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 🏡 No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 🕅 Residence	e 6 ☐ Other (Specify)
27. Manner of Death 1 ∑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		nome, farm, street, fact ify)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
29a. Certifier 1 💢 Certifying P (Check only one)	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b Signature and title of certifier			29c. License number	29d.	Date signed (Month, Day, Year)

D09357

April 20, 2006

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

John R.

31. Date filed (Month, Day, Year) APR 2 2006

Lilly,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 5804 Baltimore Ave., Hyattsville, MD 20781

Hospital or Attending Physicien: The law requires that the death certificate be executed Division after death. filled 24 hours a within 24 ho To the Function the

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 2006

Registrar DHMH 17 Rev 1/2001

Medical

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	Plea	ase Type o	r Prin'	t in Bla	ck in	delibl	e Ink	(. Assı	ure A	II Copie:	s Aı	re Legi	ible.		
					Depa	artmen	nt of H		and M	Mental Hy		ene 0 (06	By Postania	296
1. Decedent's Name	e (First, Middl	le, Last)								2. Date of De		Day	Voor	3. Tir	me of Death
Elmer		Jarrett			1	Cross	3			April	2	3, 200	06 Year	11	:55 A.M.
4a Facility Name (/	If not institutio	on, give street and n	number)			-		4b. City, To	own, or L	ocation of Deat		4c. County			
		alth Care		iter				Hager	rsto	wn		Wash	hingto	on	
5. Social Security N		6. Sex		(In yrs. last bi	nirthday)	If Under		r If Under:	r 24 Hrs.	9 Date of Bir	irth				tate or Foreign
220-10-78		1 ½ M 2□ F			Yrs.	Months			Min.	(Month, Da	17	^(ear) 1921	Count Mary	Îan	tate or Foreign
Usual Residence of	f Decedent														
10a. State	10b. County	1	-	10c. City, Tow	wn or Lo	cation					_		10	Jd. Insi	ide City Limits
MD	Washi	ington		Hag	erst	Own								1 💢	Yes 2□No
10e. Street and Nur		.1161011		1100	2800	10f. Zip	o Code				10g	. Citizen of V	What Coun'	try?	
						1.	•	740						19.	
	ayne Av		- andont Fr	- 11 S	113 1	't'on Dage			talen (St	- it, Vac or N	-		S.A.	an Indi	-
11. Marital Status	- AT	12. Was De	Forces?		13. 1	f Yes, spe	cify Cub	Jan, Mexicar	n, Puerto	pecify Yes or No o Rican, etc.)	J-		ce - America ick, White, e		,n,
1 ☐ Never Marri 3 ☐ Widowed		If Yes C	Give	1944 – 1945	1	1□ Yes 2	2 ∏ No	Specify:	:			Specify	v Whi	te	
10	15. Deceder	nt's Education		16/	a. Decer	dent's Usua	al Occu	pation			16	b. Kind of Bu	usiness/Ind	Justry	
	cify only highes	est grade completed			(GIVe i life. [kind of wor 20 NOT u	rk done se retire	e during most ed)	t of work	ing					
Elementary/Seco Unknown		College	e (1-4or 5+)	L	abor	er					C	Constr	uctio	n	
17. Father's Name		Last)						18. Moth	er's Nam	ne (First, Middle	e, Mai	iden Surnan	ne)		
		on Cross					,			ne Taylo					
19a. Informant's Na				15	h Mailir	a Addres	~ /Stree			ral Route Numb		h or Town	Ctate Zip	Code)	
Ada G. Ci						_				rar Houte Numb Cstown,		-		Jue,	
		TIE		20b. Place				E.,	a6		_			- Str	
20a. Method of Disp 1 Burial 2 4 Donation	☐ Cremation	3 □Removal from	m State	Rest 1	tery, crem	matory or or	other plac		4	Date /26/2006		c. Location - lagers	-		
21. Signature of Fu				ICC -				ess of Facilit	lity						
> C1	A 1. /	Liconsco							Re	est Have				-	
P 3.W	rank >	Mine								Ave., Ha			n, MD	2	1742
23a. Part1. Enter the	ne disease, or	r com the tions that t only on cause on	t caused the	ne death. Do	not ente	ar the mod	le of dyir	ng, such as	cardiac	or respiratory a	arrest,		1	Approx	al Between
diveri	it itimeses.	Orny or	Buch					1					4	Onset	and Death
Immediate Cause ((Final		1	~~~		001	(ANT	05	u D	116	1+ aS	0		
disease or condition resulting in death)	n	a		DYO	70	14	-	1.1.1.	C.	7 4	12	, , ,			
		5		Due to (or as a	consequ	uerice or):		0			. ,	reas	1		
		b .	~ ~ c	1 5	ta	92		Nev	101	1	111	'cas	1		
Sequentially list con			Di	ue to (or as a	conseq	uence of):	4			,]		
cause. Enter Unde Cause (Disease or	erlying												į		
that initiated events resulting in death) L	S	С.	Dı	ue to (or as a	conseq'	uence of):		-							
resulting in Gounn -	_ası												1		
	•	d													
Cadli Other signif	*** conditie	contributing to	doath but	resulting	- the II	-darking (ee di	in Part	•	23h Dic	+oha	200 Hea CD	-teibute to	the CF	use of death?
Part II. Other signifi	icant conunc)ns contributing to	deatn out,	101 resulting .	in the u	.derlying	ause y	/ON III Face.	•						
	i ab	itas	Me	litu	1 S					וו	Yes	2□ No	3 Prob	abty	4 Unknown
,	HYS	zzata	nsi	0 5						24a. Was	s an ai		avai	ailable p	opsy findings prior to n of cause
	,									10	Yes	2 NO	10	lYes	2□ No
25. Was case refer	red to medica	.1						oe Piac	- of Dag						
examiner?		Hospital:				-D.D.	Ot	thor:		th (Check only o	- 11	- 70"			
1 Yes 2		1L	☐ Inpatient	-			UA	4 62 NU		ome 5 Resi)	
27. Manner of Death 1 □ Hatural 2 □ Accident	th 5 ☐ Pending investig	9	ite of Injury Ionth, Day Y	(ear)	Time of Injury	f Z	28c. Injur Wor 1 □	uryat ork?]Yes 2 □ I		28d. Describe	how	njury occur	red		
3 ☐ Suicide 4 ☐ Homicide	6 Could r	not be 28e. Plac	ace of Injury ilding, etc. (y - At home, fa (Specify)	arm, stre	et, factor	y, office			28f. Location (City or To			er or Rural	Route	Number,

Physician /Medical Examiner

Sequentially list condition any, leading to immediate. Enter Underly Cause (Disease or injuthat initiated events resulting in death) Las Part II. Other significa

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

Pages 1 end 2 should be filed within 72 hours efter death with the Meryland

Baltimore, Maryland 21215-0020

Department of Health end Mentel Hygiene. Important: or items 23s or 28s-f show important: If Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other treumatic event, the Madical Examiner must be notified at

by Physician/Medical Examine ed by the ettending physician end deteched for use as the bunal-trensit Be Completed Medical Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed to completely filled in by the funeral director, page 2 should be detentially the funeral director, page 2 should be detentially

Division of Vital Records, P.O. Box 68760,

WH-4+1

State Registrar

31. Date filed (Month, Day, Year) 25

29b. Signature and title of certifier

ARID

29a. Certifier (Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

006039

1 crifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1126

29d. Date signed (Month, Day, Year)

0

	•	For State Registrar	State of Marylar	•	artment of H tificate of			giene. U U leg. No.	6 14297
Physicia /Medic		Decedent's Name (First, Middle, Last) George	rdway	C1a	rk		2. Date of Dea Month		3. Time of Death 2006 7:40 PM
Examination Funeral Director		5. Social Security Number 6. Security Number 1.12	uare Host	last birthday) Yrs.	4b. City, Town, of Control of Con	If Under 24 Hrs	S. 8. Date of Birth	4c. County of Poly (1920)	
72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinat must be notified at	ctor	Usual Residence of Decedent		ity, Town or Lo Parkvi					10d. Inside City Limi
h with the 23a or 28 81 be not	ai Director	10e. Street and Number 8810 Walther Blvd	1., #3408		10f. Zip Code	1234		10g. Citizen of Wh	nat Country?
urs after dea st, or Items	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW		Was Decedent of H f Yes, specify Cubin	dispanic Origin? (san, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race Black, Specify:	American Indian, White, etc. White
within then.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	orking	16b. Kind of Bus	,
should be tiled and Mentel Hygi marked other umatic svent, I	To Be C	17. Father's Name (First, Middle, Last) Paul Graham Clark				18. Mother's Na	me (First, Middle, M. Ordwa	Maiden Sumame,	
s 1 end 2 should f Health and Men Itsm 27 is marke other treumatic		19a. Informant's Name/Relationship (Ty Marianne Clark (V	life)	8810	Walther		408, Parl	kville,	MD 21234
nent o ant: If ury or		20a. Method of Disposition 1XX6urial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	. Olive	sition (Name of natory or other place t Cemete	ry 4-2		20c. Location - C Frederic	
Departr Imports any Info		21. Signature of Euneral Service Licens	all	22	Name and Addre Hardest 12 Ridg	ss of Facility y Funera ely Aven	1 Home, lue, Anna	P.A. polis, M	D 21401
ysicie	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consection of the to	quence of):	failur	le Lene	Ši Š		Interval Between Onset and Death
e ettending ad for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	aldeath 3□	Ectopic pregnancy	1		23d. Date Monti	
gue de de	۵	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.		_	ute to the cause of death?
ate has b	Completed	1					24a. Was a autops perfor	sy pri med? de	ere autopsy findings availal or to completion of cause of ath? Yes 2 No
i di i	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur War	er: 4 \(\sum \) Nursing I	eth Check only or Home 5 ☐ Resident 28d. Describe h		
irs efter deat ral Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office	9	28f. Location (S City or Town		or Rural Route Number,
Fune Fune	ledical	one)	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the tire restigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) and mani late and place, an	ner as stated. d due to the cause(s)
vithin 2 To the complet	M	29b. Signature and title of certifier	Apo		29c. Licens			29d. Date signed	(Month, Day, Year)
Star Registra		30. Name and address of person who combined the part of the part o	mpleted cause of death (Ite CNE ROATH 32 egistrar's Sign	900	- 0	nklin S	quared	R. Balt	more, MDal

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 **Physician** April 18, 9:27 M Amedeo Conti /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 73 1933 Italy Director 579-58-4620 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.
Iom 27 is marked other than "natural", or items 23a or 28a-f show sther treumatic event, the Medical Examinar must be notified at 1X Yes 2 No Directo Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21409 1223 Destiny Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: ģ 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Tile Setter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maria Bosica ပ Pasquale Conti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health at Importent: If Item 27 is any injury or other treu 1223 Destiny Circle Annapolis, MD 21409 Maria Conti/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 04/21/2006 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 6 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Winknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy has certificate 2 .No 1 Yes Hospitel or Attending Physician: : After this certification of tuneral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ № 1 Dipatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a 1D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of 29c. License number 30. Name and add no completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) legistrar's Signature State APR 2 0 2006 Registrar

			State of Maryland / Department of State Ragistrar State of Maryland / Department of Certificate			giene	6 14299
***	Obveisi	Ä	Decedent's Name (First, Middle, Last)		2. Date of De Month		3. Time of Death Year
	Physicia /Medic		Richard Albert Dutton		April	22 2	006 8:30 P ^M
	Examin	er		m, or Location of Death		4c. County o	
	**		Atlantic General Hospital Ber 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birt	Worc	9. Birthplace (State or Foreign
36	Funeral Director		723-07-9800 1XIM 2 F 77 Yrs. Months Dat	ays Hours Min.	8. Date of Bird (Month, Da July 2	y, Year) 8, 1928	Birthplace (State or Foreign Country) MD
	W		Usual Residence of Decedent				10d. Inside City Limits
	shov	ō	10a. State 10b. County 10c. City, Town or Location 10c. City				MXYes 2 □ No
	28a-f	rect	MD Worcester Ocean City 10e. Street and Number 10f. Zip Cod	de		10g. Citizen of W	hat Country?
	3a or	ā		21842		USA	•
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of If Yes, specify 0	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No		- American Indian,
36	or it	by Fu	Amad Forces? 1 Never Married 2 Married Married		, , , , , , , , , , , , , , , , , , , ,		White
21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "neturel", or ttems 23a or 28a-f show ovent, the Mudical Examinat must be positived as	ed b	15. Decedent's Education 16a. Decedent's Usual Oc	ccupation		16b. Kind of Bus	
215	hin 72	Completed	(Specify only highest grade completed) (Give kind of work do	one during most of worki	ing		,
213	ed wit	Com	12 Banker				overnment
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "neturel; or tteme 23a or 28a-f show eumatic event, the Mudical Examinat must be multiped at	Be	17. Father's Name (First, Middle, Last) Henry Dutton	18. Mother's Name		Maiden Sumame	1)
<u>2</u>	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or other treumatic events.	ျှ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str.	Anne Bev		ar City or Tours	State Zin Codel
Z	od 2 s lth an 27 is r treur		Dana Lynn Malone 2205 Burgee				
Baltimore,	s 1 ar		20a. Method of Disposition 20b. Place of Disposition (Name of		Date		City or Town, State
<u>e</u>	Page nent o ant: if ary or		4 Donation 5 Other (Specify) Woodlawn Cemeter	ry 4-27	'- 06	Baltimor	re. Md.
att	permit. Departr tmporte any inju			ddress of Facility 108		ım St.,	
ш	60550		1 100	Maryland 21			
			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line.	_	_		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive F Due to (or as a consequence of):	"ulmonary	Dise	ase	
.6	Examiner		Sancia	-			
7 I		ner	Sequentially list conditions b. Due to r as a consequence of): cause. Enter Underlying				
41	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Examiner	that initiated events c. Renal Fail re				
28°,	be exe cian a ourial-	i Ex	resulting in death) Last Due to (or as a consequence of):				
19.00	physics the b	dicai	d				
8 45 %	eath certifica attending ph for use as ti	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date	of delivery
-2-8-	e death the atte	Physician/Med	in the past 12 months? 1 Ves 2 No 9 Unknown			Mon	th Day Year
β. 6 P.O	at the d f by the stached	Phys	9 Unknown				
00 80	res that signed to be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	∌given in Part I.			bute to the cause of death? 3 Probably 4 Dunknown
ु शु	v requi	Completed					
~ 28	e tay	mp			24a. Was autor perfo	osy pr	Pere autopsy findings available fior to completion of cause of eath?
tal	icien: Th certificate rector, pag	e Co	25. Was case referred to medical	26. Place of Death	1 Yes	-X	☐ Yes 2☐ No
'. <u>≥</u>	ysicien: s certific director,	ToB	examiner?	Other		dence 6 Othe	r (Specify)
200	ling Ph		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☑Natural 5 ☐ Pending			how injury occurre	
utten 123-	eath or:	catio	2 Accident investigation M	1 Yes 2 No			
	F 8 F 5	ertification:	4 Homicide 28e. Place of Injury - At home, farm, street, faclory, offi building, etc. (Specify)	ice	28f. Location (City or Tox		r or Rural Route Number,
	spital	C	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	ne time, date and place,	and due to the	cause(s) and mar	ner as stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edio	(Check only one) 2 ☐ Madical Examiner: On the basis of examination and/or investigation, in manner stated.	ny opinion, death occurr	red at the time,	date and place, a	nd due to the cause(s)
	To the To the Complex	Σ		cense number			(Month, Day, Year)
			on Calinus III	56312		April 2	2,2006
			30. Name and dress person who completed cause of death (Item 23a) (Type, Print) Gregory W. STamnas, MD 9733 Healthi 31. Date file. (Morth, Day, Year) APR 2 4 2006 32. Figistrar's Signature	WAY Doug	Barlin	MD 219	311
	Sta	te	31. Date file \(\text{Mon}(th, Day, Year) \) 32. Figistrar's Signature	- 1/1 We	לייוי נפת	, -10	OF:
*	Registr	100	APR 2 4 2006 Mese & April				

			For State Registrar	State of Marylar		artment of H			iene	14300
	Dhuaiai	a h	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medi		Helen Mildr	ed Dement				April	23,2006	8:47А м
	Examir	er	4a. Facility Name (If not institution, giv Southern Mary	-	al_	4b. City, Town, or Clint		ŕ	Prince (Georges
	Funeral Director		5. Social Security Number 6. S 224-22-6753 Usual Residence of Decedent	6ex 7. Age (In yrs. 8.		If Under 1 Year Months Days	Hours Min. Dece	8. Date of Birth (Month, Day, mber 2	Year) 9. Bii	thplace (State or Foreign ountry) Virginia
	Maryland fahow	or	10a. State 10b. County MD Char		ty, Town or Lo	Lotte Ha	11			10d. Inside City Limits 1 Yes 2 No
	3a or 28e	Funeral Director	10e. Street and Number 13710 Dyson P	lace		10f. Zip Code 206	22	1	0g. Citizen of What C	ountry?
920	be filed within 72 hours after death with the Maryland tal Hygiene. Indocther than "natural", or Itame 23e or 28e-1 ahow avant, the Medical Exerting must be redified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
215-0	within 72 ho ene. than "natur Le Medical.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ng	16b. Kind of Business	,
Maryland 21215-0036	be filed within tal Hygiene. d other than	Be Con	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	<u> </u>	1	18. Mother's Name		Retail (Store
yla	should be and Mental a marked o	2	Emmitt Edwards			-	Mary Ed			
	nd 2 lith a 27 is r trau		19a. Informant's Name/Relationship (Rex Coffey/Sor	1 ,	1371	O Dyson	Place,C	harlot	City or Town, State, te Hall,	MD 20622
Baltimore,	permit. Pages 1 a Depertment of Hes Important: If itam any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil	Removal from State M+	cemetery, cres	esition (Name of matory or other place fort Cem	9)		20c. Location - City of lexandri	
Balt	permit. Depertimport Import		21. Signature of Funeral Service Lice	6 6 10094	4	R. Name and Addres AREHART -	ECHOLS	FUNERA	L HOME,P	.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deal one cause on each line. a. ACUTE Due to (or as a consect	MYO	er the mode of dying				Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
387	physicate by the b	dicai		d						
P.O. Box 6	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	signed by	۵	Part II. Other significant conditions of CEREBRO VAS			, ,	n in Part I.		pacco use contribute t	o the cause of death?
of Vital Records,	e law require has been sig je 2 should b	Completed	HYPERTENS			•		24a. Was a autops	y prior to	utopsy lindings available completion of cause of
alF	icien: The l certificate ha rector, page	CO	25. Was case referred to medical					1 ☐ Yes 2	2 ☐ No 1 ☐ Ye	s 214No
Ę	ysicien: is certifica director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA Othe	26. Place of Death		ence 6 ⊡Other <i>(Sp</i> e	acity)
J Of	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	эспу)
Division	To the Hospitel or Attanding Physicien: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	1 Matural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b determined	e Geo Blace of Injury. At h	ome, larm, str	M 1 🗆 Y	es 2□No	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attanwithin 24 hours efter deat To the Funerel Director:	Medical C	29a. Certifier 1 Certifying Pr (Check only 2 Medical Exer	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deatl ation and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
)	To the withing To the comp	×	29b. Signature and title of confider			29c. License			9d. Date signed (Mon IPRIL 23)	
(B 4		30. Name and address of person who TERRY A. JODRIE	completed cause of death (Item, M.D. 7503	m 23a) (Type, SURRI	Print) ATTS ROA	D, CLIWT	ON, MAN	LYLAND	20735
	Sta Registr		31. Date liled (Month, Day, Year) APR 2.4	32. Bagistrar's Sign						

			For State			Depa	artment of Heartificate of De	alth and M	ental Hygie	ene 0 0 6	1.30
			Registrar			Cer	lineate of De	ealii). No.	O Time of Doort
	Physicia /Medic		Decedent's Name (First, Middle, Las Joseph Richa						2. Date of Death Month April	Day Year 20 2000	10011 411
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or Lo	ocation of Death	'	4c. County of Dea	ith
			Dorchester Gener	al Hospita	al		Cambri			Dorche	
	Funeral Director		5. Social Security Number 6. Se 192–44–8696	ex 7. Ago 1 X .M 2□ F	e (In yrs. last bii 53	rthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Oct. 16	(ear) 9. Bit 1952 Det	nthplace (State or Foreign ountry)
			Usuel Residence of Decedent						000. 10	1752 10	.niby i vanita
_	yland		10a. State 10b. County		10c. City, Tow	n or Lo	cation				10d. Inside City Limits
\bigcup	Mar in st	ţ	MD Dorche	ester			East Ne	ew Market	t		1 ☐ Yes 2 XNo
)	1 the	Director	10e. Street and Number				10f. Zip Code		100	j. Citizen of What C	ountry?
ζ	death with the Maryland ms 23e or 28a-f show grast be nutitied at		3905 Lee Court				21	1631		USA	
2	ns 2	lera	11. Marital Status	12. Was Decedent I	Ever in U.S.	13.	Was Decedent of Hispa f Yes, specify Cuban, I		cify Yes or No-	14. Race - Am	
9	after or ite	/ Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give				Mexican, Puerto I Specify:	Rican, etc.)	Black, Whi	_{te, etc.} vhite
$\frac{3}{2}$	irei',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	- 1979	1				opeony. V	MITCE
ก็	72 hours neturel',	Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a	. Deced (Give	dent's Usual Occupation kind of work done duri DO NOT use retired)	on ing most of workir	ng 16	b. Kind of Business	/Industry
V	within ene. then "	du	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT use retired)				
V	y be //gier	Ö	12	6			school te			<u>high scl</u>	100l
2	al Hy al Hy al oth	Be	17. Father's Name (First, Middle, Last)				18	3. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>a</u>	Ment Ment arke	ို	Joseph Depto					Margaret	Shimko		_
B	and and is my		19a. Informant's Name/Relationship (7	Type, Print)	195	. Mailir	ng Address (Street and	d Number or Rura	l Route Number, C	City or Town, State,	Zip Code)
Σ.	and sealth m 27		Diane Depto	wif			Lee Court			et, MD 21	1631
ore e	of He		20a. Method of Disposition	Damaual from State	20b. Place o cemete	f Dispo	sition (Name of natory or other place)	D	ate 20	c. Location - City or	Town, State
Ĕ	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then any injury or other treumatic event, Ira Mone.		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Specify				n Cemetery	7 4/25	5/06 M	iount Plea	sant. PA
aitimo	mit.		21. Signature of Funeral Service Licen	see	112200	_	2. Name and Address of			eral Home	
Ö	Depariment Department Important Impo		B-10 B			7	00 Locust				
14			23a. Part1. Enter the disease, or comp	plications that caused	the death. Do	-			The state of the s		Approximate
	2.0		shock, or heart failure. List only of Immediate Cause (Final	one cause on each lir	10.		11/2/7		-/ .		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ACUT	- /VI)	0 6 1	mtiri s	- W/07c	1100		30 min
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	ted 1sit	Examiner	cause. Enter Underlying Cause (Disease or injury	4,00	1000	Done					2 44
	and and il-trai	хаг	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):	~~~				27-31
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00	cate phys			d							
	certificat Iding phy Ise as th	hysiclan/Medl	IF FEMALE:	23c. If yes, outcome	of pregnancy					and Date of Jan	P
Š O	death o	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
5	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time of death	3 [
	w requires that the death certificate been signed by the attending phys should be detached for use as the	۵.	Part II. Other significant conditions of	ontributing to death b	ut not resulting i	n the u	nderlying cause given i	in Part I	23e. Did toba	cco use contribute t	o the cause of death?
	requires I	l by	•	3	3		,		1 ☐ Yes	2 No 3 P	robably 4 Unknown
cords	requ	etec							-		
T)	a a c	ompleted							24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
	That ate	Co							performe 1 ☐ Yes 2	d? death? ZNo 1 ☐ Yes	2 J No
E E	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					6. Place of Death	(Check only one)		
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	ding Phys h. After this funeral di	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui	y Year) 28b.	Time of Injury	Work?		28d. Describe how	injury occurred	
SION	endi eath. or: A he fu	catl	2 Accident investigation				M 1 Yes	s 2 No			
<u> </u>	re Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ary - At home, fa c. (Specify)	arm, str	eet, factory, office	2	28f. Location (Stre City or Town, 3	et and Number or R State)	ural Route Number,
	rs aft	Cel		N. Committee				, l			
	To the Hospitei or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exam	niner: On the basis of	examination an	e, death nd/or inv	n occurred at the time, vestigation, in my opini	date and place, a ion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner sta	ued.		29c. License nu	umber	204	. Date signed (Mon	th. Dav. Year)
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							10-6	200	/+	pru 4	~ · · · ·
			30. Name and address of person who o					••		40	
			Michael Fade			OTT	ins Ave.,	Hurlock,	MD 216	43	
	Sta Registr		31. Date filed (Month, DAPR) 2 4	1 2006	alue 1	K	Loselle				
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			For State Registrar	State	e of Ma	arylan	-	artmen rtificat				lental Hy	giene Reg. No			43	02
			1. Decedent's Name (First, Mid	dle, Last)						and and and and and and and and and and		2. Date of De	ath Dav	y Year		3. Time of	Death
	Physici /Medio		Dorothy Eiche	lberger				,				4	20	2006		7:25	P M
	Examin		4a. Facility Name (If not instituti	, ,				4b. City,	Town, or	Location	of Death			County of De			
			Berlin Nursin				d= = 4 t	Ber1		If Under	24 Hrs	0.0-1(0:		Worcest		(0)	. 5
	Funeral Director		5. Social Security Number 057-14-8395	6. Sex 1 ☐ M 20€	-	9 (in yrs. i	last birthday) Yrs.	Months		Hours	Min.	8. Date of Big (Month, Da 8/28/	tn sy, Year) 1000	9. 8	Country	(State of	r Foreign
			Usual Residence of Decedent			<i></i>					<u> </u>	0/20/	1900			TID	
	nyland how		10a. State 10b. Coun	у		10c. City	y, Town or L	ocation							10d	. Inside Cit	•
	h the Maryland r 28a-f ahow r notified at	cto	MD Wor	cester		Ве	erlin									1 🗌 Yes	2X No
	or 2	Funeral Director	10e. Street and Number					10f. Zip					10g. Cit	izen of What C	Country	?	
	s 23a	Ta la	9715 Healthwa	· · · · · · · · · · · · · · · · · · ·	D d 1 (Company Service	6 40	West David		1811	-1-0/0-			USA 14. Race - Am		Indian	
	itam itam	Ë	11. Marital Status 1 Never Married 2 Married	Ame	Decedent 6 d Forces? 'es 2 ⊡√		.5. 13.	Was Dece	cify Cuba	in, Mexica	n, Puerto	ecify Yes or No Rican, etc.))-	Black, Wh			
38	urs aft	þ	3 🖾 Widowed 4 🗆 Divorce	If Yes	or Dates:	••		1 🗌 Yes	2 XNo	Specify:				Specify:	Whi	te	
215-0036	fied within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or items 23s or 28s-1 show int, the Medical Examiner must be notilised at	Completed	15. Decede (Specify only high	ent's Education	todi		16a. Dece	dent's Usu	al Occup	ation	et of work	ina	16b. K	ind of Busines	s/Indus	stry	
2 4	ithin in ith	nple	Elementary/Secondary (0-12)		ge (1-4 <i>o</i> r 5	+)		kind of wo DO NOT u				9					
102	ygier ygier her th	ပ်	12		<u>.</u>		Pro	fessi	onal			(Fi		tertair	men	t	
T PE	be fill H off	Be	17. Father's Name (First, Middle							18. Moth	ers Name	e (First, Middle	, Maiden	Sumame)			
ਜੂ <u>ਵ</u>	2 should be filed within and Mental Hyglene. Is marked other than aumatic avant, the Ma	ပ	John B. Thomas 19a. Informant's Name/Relation				19h Maili	na Address	(Street			es Frie			Zin Co	nde)	
Chel., Mary	s 1 and 2 should be filed within Health and Mental Hygiene. Itam 27 ta marked other than other traumatic avant, the M		Pierce Eichell					•				VA 2342	26.57	, rown, state,	ZIP O	,00,	
e Č	is 1 and 2 of Health Itam 27 other tre		20a. Method of Disposition			20b. P	lace of Disperent	sition (Na	ne of			VA Z34		ocation - City o	r Town	, State	
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	/Medical Examiner		resulting in death)	1 2	e to for as	a consequ	uence on:	1	4.	h (G-	0	~ D	۲.		(
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89	Attending Physician: The law requires that the death certificate be executed of death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Med	IF FEMALE:				.										
Division of Vital Records, P.O. Box 6	eath certific attending pl	by Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	10L	outcome ive birth	2 Fetal	1 death 3[Ectopic p						23d. Date of d Month	elivery Da	ay Y	/ear
<u>.</u>	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown		regnant at Inknown	time of de	eath 5(Other (sp	oecify)							,	
م.	es that thighed by I	h H	Part II. Other significant condi	tions contributing	to death bi	ut not resi	ulting in the u	nderlying o	ause giv	en in Part	l.	23e. Did	tobacco i	use contribute	to the	cause of de	eath?
Sp	puires n sign ald be											10	Yes 2	□No 3□F	robab	ly 4 🔀	Inknown
3	w require been sign	lete										24a. Was		24b. Were a	autopsy	findings a	available
æ	nn: The lav lificete has or, page 2	Completed			-							auto perfe	psy ormed? 252 No	death?	,	letion <i>o</i> f ca □ No	iuse ol
ital	ilcian: Th certificete rector, pag	BeC	25. Was case referred to medic	al						26. Place	e of Deat	h (Check only					
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isio	ttendi death. ctor: A y the fu	cat	Ž Accident inves 3 Suicide 6 Coul	tigation	llana of Imir	At he	ome, larm, st	M		Yes 2		28f. Location (Stroot as	d Number or	Dural C	Davido Altumi	hos
)	lor A after Dirsc	Certification;	4 ☐ Homicide dete	mined 200. E	ouilding, etc	c. (Specif)	y)	reet, ractor	y, onice			City or To			רו ומוער	IOUTO NUITT	<i>J</i> 61,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certify	ing Physician: To	o the best	of my kno	wledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s	and manner	as state	ed.	
	ha Ho n 24 } he Fu xletely	Medical	(Check only Medic	if Examiner: On t	he basis of manner sta	examina	tion and/or in	vestigation	i, in my <i>o</i>	pini <i>o</i> n, dea	ath occur	red at the time,	date and	d place, and du	ue to th	e cause(s)	1
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			/V Vola	eed		ب	8	Z	1	16	7		4	120	10	6	
			30. Name and address of person	n who completed	cause of d	eath (Item	23a) (Type	Pript)	1 ,	11		60	. 1	Telene	16	2 10	DURI
32	ET 5		31. Date filed (Month, Day, Yea	1 Duce	32. Degistra	ar's Signa	007	Cer	121	rede	ver	. 1 ew	ich	45 Bee	7	(19)	177
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Physician /Medical Examiner		I. Decedent's Name (First, Middle, Last) Esta Marie Fergu Ia. Facility Name (If not institution, give street and number Dennett Road Manor Nursi:	son or)	4b. City, Town, or Location of Death	2. Date of Death Month Apr. 22	Day Year	
Funeral Director		5. Social Security Number 212–24–0739 6. Sex 1 ☐ M 2 💢 F 7.	Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Nov. 6,	Year) 9. Bin 200 1927 Wes	hplace (State or Foreign untry) t Virginia
the Maryland 28a-f show cutified ut		MD Garrett Oe. Street and Number	10c. City, Town or Lo	Oakland 10f. Zip Code	10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 X No
Tey, INIAI yidilid ZIZIS-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. item 27 is marked other then "natural; or itema 23a or 28a-f show other traumatic event, the Medical Exampler mast be notified at To Be Completed by Funeral Director		282 O Haver Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	∑ No		550	USA 14. Race - Ame Black, Whit	rican Indian,
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C, Ivical thand 2 sh Health and em 27 is m ther traum	-	19a. Informant's Name/Relationship (Type, Print) Jerry L. Ferguson/Son 20a. Method of Disposition		ng Address (Street and Number or Ru O'Haver Road, Oal	kland, Ma	-	550
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ificate be executed Applysician and as the burial-transit edical Examiner edical Examiner		Sequentially list conditions, I any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Histo Cue to (or Lasto Corrections) Due to (or Due	ation pnot as a consequence of): ry of cere as a consequence of)		isease		Approximate Interval Between Onset and Death 6 wks months yrs wks
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To the Hospital or Attendition 24 hours after death. To the Funeral Director: A completely filled in by the funeral Certification.	יבמוכמו	(Check only 2 Medical Examiner: On the basi and manner	s of examination and/or in		urred at the time, da	te and place, and due	to the cause(s)
Tot with Tot com		29b. Signature and title of certifier 30. Name and a mess of person who completed cause	d death (Item 23a) (Type.	29c. License number D30035		d. Date signed (Mont	
State Registrar	1	Donald R. Richter, M.		•	Oakland,	MD 2155	50

		·	1 - For State Registrar	State of Maryland		rtment of H tificate of I		R	eg. Nő.	14305
1	Physici /Medio		Decedent's Name (First, Middle, Last) Floyd Owen	Green				2. Date of Deat Month April (3. Time of Death
	Examin		4a. Facility Name (If not institution, give s Memorial Hosp			4b. City, Town, or Easto	Location of Death		4c. County of D	Death
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Balt	permit. Peg Depertment Important: I eny Injury o		21. Signature of Funeral Service License	Brînce	22	Name and Address Bennie S 426 Dove	ss of Facility Mith Fune rStreet,	ral Home Easton,		
			show, or heart failure. List only or	cations that caused the death.					est,	Approximate Interval Between Onset and Death
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in the	Examiner			Due to (or as a conseque	ince of):	iopatt	ry			
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Division	2 = = 0	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At horr building, etc. (Specify)	e, farm, stre	eet, factory, office	:	28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
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	To the To the comp	W	29b. Signature and title of certifier	West MD		29c. Licenso	905665	9 2	9d. Date signed (N	1006 106 10-216/3
+	VA		30. Name and address of person who co			Print) IRORA	ST, CAM	BRIDL	E MI	0-2/6/3
	Sta Registi		31. Date filed (Month, APR 2 1	32. Registrar's Signatu	ге	A.R.				

## A City, Town, or Location of Death ## ACERSTOWN ## AVENWOOD LUTHERAN VILLAGE ## BAYENWOOD LUTHERAN VILLAGE ## BAYENWOOD LUTHERAN VILLAGE ## BAYENWOOD LUTHERAN VILLAGE Funeral Director	P M or Foreign
Physician Medical Examiner April 24, 2006 12:5	or Foreign
As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As County of Death As Co	or Foreign
RAVENWOOD LUTHERAN VILLAGE Funeral Director S. Social Security Number S. Social	City Limits
S. Social Security Number 6. Sex 214-09-6551 1 m 2 m 7. Age (In yrs. last birthday) 1 m 1	City Limits
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	City Limits
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	;)
grigging to be signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
Marjan 9 Hug D28365 4-25-06	
Manyen 9 Hudy D28365 4-25-06 30. Name and address of person who combleted cause of death (tem 23a) (Type, Print) THW2 HL. J SHAP 368 mill Street Hagrestown.	
State Registrar APR 2.5 2006 32. Registrar's Signature	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Annette Ezell Grim, Ph.D. 23,2006 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11102 Charlie Dr. Bishopville Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M **3**□F Yrs. June 19, 1940 323-32-1908 Director 65 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√XNo Director MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11102 Charlie Drive 21813 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrator University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Woodrow Schram Rosa Franich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Grim, III (husband) 11102 Charlie Dr., Bishopville, Md. 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of Hi Important: If ites sny Injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 4/24/2006 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md.

23a. Part1. Enter the disease, or componications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Leionyosarcoma 1.5 yeu resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) P.O. I 1 ☐ Yes 2 🗓 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home \$\text{ Residence} 6 Other (Specify) ဥ 1 Yes 2 No 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely filled in by the fu death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

State

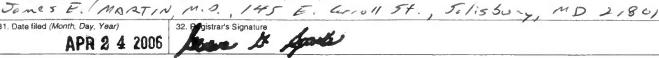
31. Date filed (Month, Day, Year) APR 2 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier 2

4 - Homicide

(Check only one)



Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

030690

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dev. Year)

1. 55 p. v				1 - For State			id / Depa	artmen	it of Health ar	-	ygiene	e 2 nn c	Marine Marine	300
3		*		Registrar 1. Decedent's Name (First, Middle, La	st)			inout	o or Boarn	2. Date of D	Reg. No). L. Q U U	3. Time of	of Death
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	7	/Medi Examir		4a. Facility Name (If not institution, giv					Town, or Location of			. County of Deat		
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)00C		Funeral		5. Social Security Number 6. S	ex 7 □ M 2⊠F	Age (In yrs.	last birthday)	If Under Months		Min. (Month, D	ay, Year,	9. Birt Co	hplace (State untry)	or Foreign
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9		ow ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside (City Limits
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C		deeth with the Maryland ms 23a or 28a-f show rmust be nutified at	Funeral Director	16200 A.E. Mullin	nix Road				21797			United	States	
		or dee	ne	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Dece	dent of Hispanic Origin cify Cuban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ame Black, White		
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<	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exeminer must be notified at once.	1	19a. Informant's Name/Relationship (1		(Street and Number					
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	B	death atter	clar	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant	2 Feta	al death 3	☐Ectopic p				Month Month	Day	Year
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	σ,	law requires thet les been signed b s 2 should be dete	y P	Part II. Other significant conditions	ontributing to death	but not res	ulting is the u	inderlyjng o	cause given in Part I.	23e. Did	tobacco	use contribute to	the cause of	death?
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	900	lawre as be	Completed							24a. Wa	s an opsy	24b. Were au	topsy finding	s available
	Ř	The ete h page	E							per 1 ☐ Yes	formed?	death?	2 No	cause of
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		1	For State Registrar		Sta	te of Ma	rylan		artmen rtificat			and N	lental Hy	/giene Reg. Nö.	006	to property	309
			1. Decedent's Name										2. Date of D Month	eath Day	Yea		e of Death
	Physicia /Medic		Frances	Pearl H	arman								APRIL	24,	2006		5 A M
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			RAVENWOOI							RSTC	WN If Under	24 Hrs	O Data of B		ASHING		to or Foreign
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	D	-	Usual Residence of 10a. State	Decedent 10b. County			10c. City	v. Town or Lo	cation							10d. Inside	City Limits
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HARMAN	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	edical Certification:	3 Suicide 4 Homicide	6 Could r determi		e. Place of In- building, et	jury - At h tc. <i>(Speci</i>	nome, farm, s	treet, facto	ry, office			28f. Location City or 1	n (Street al Town, Stat	nd Number or e)	Rural Route	Number,
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		1 - For State Registrar 1. Decedent's Name (First, Middle, Las	t)	(Certificat	e of Death	2. Date of De	Reg. No.		3. Time of Death
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wedic xamin		4a. Facility Name (If not institution, give			4b. City,	Town, or Location of De	ith		inty of Death	
		UNIV OF MARYLA		AL SYSTE		BALTIMORE				
neral ector		5. Social Security Number 6. Security Number 359-28-5968	7. Age	(In yrs. last birth	Months	T 1 Year If Under 24 Hi Days Hours Mi		1936	9. Birthp Cour Illin	place (State or Fore ntry) 1015
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should be detached	by	Part II. Other significant conditions of	ontributing to death bu	at not resulting in t	he underlying o	ause given in Part I.				ne cause of death pably 4 Dunkn
page 2 sh	Completed		****				24a. Was auto perfo 1 \(\text{Yes} \)	osy ormed?	4b. Were auto prior to con death? 1 Yes	psy findings avail mpletion of cause 2200
	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only o			
ector.	n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	nt 2 ER/Outp y 28b. Tir Year) Inju		OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	Home 5 Resi			y)
funeral director.	유	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At home, farm . (Specify)			28f. Location (City or To	Street and Ni wn, State)	umber or Rura	al Route Number,
by the funeral director.	rtificatio	4 Homicide determined								
lled in by the funeral director.	Certification:	4 nomicide					e and due to the	causa(s) and	l mannar ac c	tated
oletely filled in by the funeral director.	edical Certificatio	29a. Certifier 12 Certifying Ph	ysician: To the best of	examination and/	death occurred or investigation	at the time, date and pla , in my opinion, death oc	curred at the time,	date and pla	ce, and due to	the cause(s)
completely filled in by the funeral director, page 2:		29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the best of liner: On the basis of and manner sta	examination and/ ted.	or investigation	, in my opinion, death oc c. License number	curred at the time,	date and pla	gned (Month,	Day, Year)
completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of liner: On the basis of and manner sta	examination and/ ted.	or investigation	, in my opinion, death oc	curred at the time,	date and pla	ce, and due to	Day, Year)

06-02631 Joa

Please Type or Print in Black Indelible Ink

anna Hoa	ard		State of Maryland / Department of Health and Mental For State **Certificate of Death**	-		ne Holi
Phy edical Ex	/sicia		1. Decedent's Name (First, Middle, Last) Joanna Elizabeth Hoarde	Date of De Month	Day Year	3. Time of Death
edicar Ex	Kaliili	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	April 18,	2006 4c. County of	0202 hrs
			Suburban Hospital Bethesda		Montgom	
Fun Dire			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M	lin		9. 8irthplace (State or Foreign
			Usual Residence of Decedent	1/26/	1946	Country) Jamaica
_	or 28a-f show any fied at once.		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
larylanc	st onc	Director	Maryland Montgomery Rockville 10e Street and Number 10f. Zip Code		10g Citizen of Wha	
h the N			14128 Chesterfield Road 20853		United St	ates
eath wit	or items 23a must be noti	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (1) 14. Was Decedent of Hispanic Origin? (1) 15. Was Decedent of Hispanic Origin? (1) 16. Was Decedent of Hispanic Origin? (1) 17. Was Decedent of Hispanic Origin? (1) 18. Was Decedent of Hispanic Origin? (1) 19. Was Decedent of Hispanic		o- 14 Race - White,	American Indian, 8lack, etc
after de		by Fu	1 Yes 2 X No 3 Widowed 4 Divorced or Diverser or Dates:		Specify:	Black
2 hours	"natural", I Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind or during most of working life. DO NOT use re		16b. Kind of Busi	ness/Industry
036 vithin 7	other than the Medical	Completed	3 Nurse		Health	Care
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene	tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	Be Co	17. Father's Name (First, Middle, Last) Charles Hoarde 18.Mother's Nam Etta Jar		Maiden Surname)	
212 hould b	is marl	10	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	r Rural Route Nu		
and 2 sho	traum		Moye Stephenson/Daughter 2733 Atlanta Drive, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	_	D 20906 ity or Town, State
MOF Pages 1 ent of 1	r other		1 X Burial 2 Cremation 3 X Removal from State crematory or other place) 4 Donation 5 Other Specify: Goodwill Cemetery May	y 1, 200	Dictrict	of Goodwill,
Baltimore, permit Pages I and Department of Heal	mporta njury o		21. Signature of Funeral Service licensee			
Physic		-	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	5.2		
/Med ⊂xami	ical		Immediate Cause (Final disease a. Multiple Injuries			8 etween Onset and Death
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ъ	nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
e execul	hysician and e burial - transit		UNPENDED X AMENDED #10gperFH4/21/06, BMW,McCo			
3760, ficate be	g physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of de	
Box 687	e attending phy for use as the	siciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	nancy	Month	Day Y ear
D. B.	signed by the a	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	tobacco use contribu	ute to the cause of death?
of Vital Records, P.O.	signed d be det	d by				Probably 4 Unknown
ords aw requ	as been s 2 should	Completed		24a. Was auto	psy prid	ere autopsy findings available or to completion of cause of
Rec	his certificate has director, page 2 s		25. Was case referred to marked	1 ✓ Yes		ath? Yes 2 No
Vital ysician	dir bi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No No No No Other Nurs No No No No No No No N	k only one) sing Home 5	Residence 6	Other:
n of	After funera	on: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurred struck by auto	
Division tal or Attendir	irector: n by the	ficati	2 Accident Investigation			or Rural Route Number, City
Divisior	filled in	Certification	4 Homicide determined (Specify) Local Street	or Town,	State)	e & Bel Pre Rd, SilverS
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cau	se(s) and manner a	s started.
To	CON	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
5			(alall) O.C.M.E.		April 19, 200	6
			30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
-	St	ate	31. Date filed (Md PRy, Year) 1 2006 32. Segistrar's Signature			

Medical State

Carol Allan, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)



29c License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 12, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State #7, per F. Home, 4/24/06 Certificate of Death E.T., WCHD Reg. No. Amended item 1-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hall 5. Social Security Number Olomoke Inder 1 Year | If Under 24 Hrs. lor. Homo Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 200 F 229-36-474 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 'natural', or Itams 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 PNo Ocomor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) oac Was Decedent Ever in U.S Armed Forces? 11. Marital Status 12 14. Race - American Indian, Black, White, etc. I □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 D No Specify þ 3 ☐ Widowed 4 ☐ Divorced ack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other $LU\partial_{\cdot}\mathcal{L}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Menta Is markad aden ordelia Um Ke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Importent: If item 27 Is eveland Husbard 1000make 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Maccdowin Man, Park -06 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Revoice cial Home Pocomoka Ci P.O. Box 331 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or death failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** CORUNARY ATHEROSCUEROSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 28 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has page 2 certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other 4 ursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified (1 · M 0062172 4/21/2006

E.T.

State

31. Date filed (Month, Day, Year) APR 2 4 2006

SHARAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL, M.D.



Registrar

1604

MD

POLOMOKE GIY

		•	For State Registrar	State of M	arylan	d / Dep		of H	ealth a	and M	ental Hy	giene	6 14311	i
			Decedent's Name (First, Middle)	. Last)							2. Date of Dea		3. Time of Dea	ath
	Physici /Medic		Edward Joseph L	ewis								8. 2006	4:30 P	М
	Examin		4a. Facility Name (If not institution,						Location o		•	4c. County		
			Montgomery Vill 5. Social Security Number			er last birthday	Gait If Under 1		sburg		9. Data of Rief	`	gomery	
	Funeral Director		127-07-3461 Usual Residence of Decedent	1 M 2 F	87 87			Days	Hours	Min.	8. Date of Birt (Month, Da July 22	y, Year) 1918	9. Birthplace (State or For Country) New Jersey	reign
	yland		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Lin	mits
	a-f st	ctor	Maryland Montgo	mery	Mot	ntgome	ry Vil	.lage	е				1 X Yes 2 □] No
	h with the 23s or 28	ai Director	10e. Street and Number 19310 Clubhouse	Road, # 621			10f. Zip (Code 208	386			10g. Citizen of W	Vhat Country? S. A.	
36	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Exterings must be nutified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Marrie		? ^{No} A r ı	Į.	Was Decede If Yes, specif 1 Yes 2	fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	- 14. Race Blac Specify	e - American Indian, k, White, etc. : White	
21215-0036	hours tural'	q pa	3 Widowed 4 Divorced 15. Decedent	Year or Dates:	WW 2	16a Dece	dent's Usual		tion			16b. Kind of Bu	WHITE	
5	⊆ ⊆	piete	(Specify only highes	t grade completed)	- \	(Give	kind of work	k done di e retired)	uring most	t of workir	ng	166. Kind of Bu	siness/industry	
212	filed within 72 Hygiene. ther than "nither than" nither than "nither than "nither than "nither than "nither than the thing the	Completed	Elementary/Secondary (0-12)	College (1-4or 2 Years	5+)	Progr	am Adn	ninis	strat	or		I. R	. S.	
ਠੁ	m - 0 9	To Be C	17. Father's Name (First, Middle, L Alexander Lew								(First, Middle, Mitzne	Maiden Sumam T	θ)	
lary	and N		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address ((Street a	nd Numbe	r or Rura	Route Numbe	ar, City or Town,	State, Zip Code) 2088	6
≥,≤	and lealth m 27 her tr	l ,	Joy L. Lewis -	Wife	201- 5	_							ry Village, I	Md.
Baltimore,	if of H		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation		200. F	lace of Displemetery, cre	matory or oth	e of her place	9)	- D	ate	20c. Location -	City or Town, State	
量	it. Pa	. 4	 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L 		N:								hurch, Virgi	nia
Ba	permit. Pages 1 and 2 should by Oppgrantment of Health and Menta Important: If item 27 is marked any injurgagither traumatic en once.		Donald C.	Story	iny	es 1	70 Roc	·kwi	11 ₀ P	ike.	Rockvi	Chapel	ryland 2085	2
			23a. Part1. Enter the disease, or shock, or heart failure. List of							cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death	n h
	Priysician /Medical	ř i	Immediate Cause (Final disease or condition resulting in death)	a		e Card	iomyop	path:	У				1000	
	Examiner			Due to (or as		_{uence of):} ve Hea	rt Fai	i lur	e					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as			10 101							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	_{с.} Нурє	erten	sion								
o,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	ohysic the b	dicai	,	d										
9	death certificate be executed e attending physician and od for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incv						1 204 204		
Вох	atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	ideath 3[☐Ectopic pre☐Other (spe					Mor	e of delivery oth Day Year	
0	t the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
ď.	The law requires that the site has been signed by the bage 2 should be detache	by P	Part II. Other significent condition	ns contributing to death b	out not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use contr	ibute to the cause of death	1?
ecords,	w require been sig should b										101	′es 2⊠No	3 ☐ Probably 4 ☐Unkno	own
ecc	law reas be	Completed									24a. Was autop	an 24b. V	Vere autopsy findings availarior to completion of cause	able of
E E		Con									perfo	myeu: a	eath? X □ Yes 2□ No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o			
of		. To	1 Yes 2 No	1 L Inpatie		28b. Time of		4	4 🖂 Nu			lence 6 Othe		
on	Attending F r death. sctor: After by the funera	tior	1 Xatural 5 Pending 2 Accident investig		ry Year)	Injury	м	lc. Injury Work	? ′es 2 ☐ N					
Division	or Dir	Certification;	3 Suicide 6 Could n 4 Homicide determi		jury - At ho tc. (Specif	ome, farm, st	reet, factory,	office		2	8f. Location (S City or Tox		er or Rural Route Number,	
-	To the Hospital or within 24 hours after To the Funeral Dii completely filled in	aj C	29a. Certifier 1☐ Certifying	Physicien: To the best	of my kna	wiedge, deat	h occurred a	t the time	e, date and	d place. a	nd due to the	cause(s) and mai	nner as stated.	
	ne Ho	edicai	(Check only 2 Medicel E	xaminer: On the basis of and manner st	of examina	tion and/or in	vestigation, i	in my <i>o</i> p	inion, deat	th occurre	d at the time,	date and place, a	nd due to the cause(s)	
	To the within 2 To the comple	Ň	29b. Signature and title of certifier	- antimo			29c.	License	number				(Month, Day, Year)	
	10		Ving G	-411			_]	D411	62			April	20, 2006	
	10		30. Name and address of person v	who completed cause of c		1 23a) (Type, 5 29 Do	Print) ctor's	s D	rive,	, Ger	mantown	n, Maryl	and 20874	
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2	32. Begistr	rar's Signa	ture	porte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April 21, 2006 5:10 A M NINA LEE LAWSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

June 25 Frederick Frederick Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 63 Yrs. 213-40-4768 1942 Brunswick, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Directo Frederick MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itema 23a or 21703 USA 6643 Jefferson Boulevard 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Beautician Ivan's Beauty Shop 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be f h and Mental h Margaret Dunn Paul Montgomery Moss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 sh partment of Health and portant: If Item 27 is m 6643 Jefferson Boulevard, Frederick, MD 21703 Carroll L. Lawson, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or QDCE. St. Mark's Cemetery 4/24/06 Petersville, MD 4 Donation 5 Other (Specify) 21. Signifund of Funday Selvice Licensee 22. Name and Address of Facility
John T. Williams Funeral Home Williams, Barbara A. Owner 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Me too toutic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death Year ō in the past 12 months? Month Dav 4□Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be Respondery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an U enous autopsy certificate has rmed? (OPD 1 Yes 2 No 1 Yes rector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3□ DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pellil To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

LOWNIE

APR 2 4 2006

31. Date filed (Month, Day, Year)

00061172

Frederik Hospital

			For State	State of Marylar		artment of F tificate of I				14316
			Registrar 1. Decedent's Name (First, Middle, La	st)		timodio or	D 0 0 11 1	2. Date of Deat		3. Time of Death
	Physici		William	Clark L	ippharc	l Jr.		Month April	13 2006	5:40 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Deat	
			Crofton Conval	escent Center		Crofto	n		Anne Aı	cundel
	Funeral		Social Security Number 6.		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign
	Director		370-07-4090	X M 2□F 86	Yrs.	World S Cays	, rours	May 22,	1919 Was	hington, DC
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty. Town or Lo	cation				10d. Inside City Limits
	sho	ក			Miller					1 ☐ Yes 2 X No
	the N	Director	10e. Street and Number	munuci		10f. Zip Code		1	0g. Citizen of What Co	unto/?
	with po a		1397 Antrim Dri	***		101. Zip 0000	21108	'	USA	, and y .
	leath	Funerai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	
2	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or teme 23s or 28s-f show int, the Madical Examinar must be notified at		1 Never Married 2 Married	Armed Forces? 1X Yes 2 □ No If Yes, Give				o Rican, etc.)	Black, Whit	
3	ours a	<u>8</u>	3 ☐ Widowed 4 XDivorced	Year or Dates: 1941	-45	1⊡ Yes 2XXXNo	Specify:		Specify:	White
ה ה	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Business/	Industry
7	ithin	du du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	d)		D	
4	led w lygier her tl		12	3	Print	er	10 Mathada Nad	an (Fire Adidala I	Printing	
2	12 should be filed within h and Mental Hygiene. 7 Ie marked other then " fraumatic event, the Mac	Be	17. Father's Name (First, Middle, Last					ne (First, Middle, M		
<u></u>	d Mer nark	၉	William C. Lipp 19a. Informant's Name/Relationship		10h Mailie	a Address (Ctrost		Louise	City or Town, State, 2	Zin Cadal
<u> </u>	d 2 sl th and 7 ie r traur		71.0			•				
ט ט	Heali Bm 2		Jean Marie Lipph 20a. Method of Disposition			sition (Name of natory or other place			1e, MD 211 20c. Location - City or	
	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Importent: if itsm 27 is marked other then eny injury or other traumatic event, the Magnee.		1 XBurial 2 ☐ Cremation 3	THOUSE HOUR STATE			1			
3	artme orten Injury	1	4 □ Donation 5 □ Other (Speci 21. Signature of Foreral Service Lice			Nat. Cen	ss of Facility		Arlington,	VA
Ö	Depe impo eny i		150H 1	41/1		Hardesty	Funeral	Home, P.	A. Sills, MD 2	21054
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dee	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate
	Physician		Immediate Cause (Final	one cause on each lipe	1	Tic	C.			Interval Between Onset and Death
ć	/Medical		disease or condition resulting in death)	a. Due to (or as a consec	Wence of):	+ 1/20	ARICIE	neg) years
	Examiner			. () r	-44	0515				2 weeks
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor sec	quence of):					2 weeks
	cuted nd ransi	Examin	that initiated events	e. #3	ver	uri	cemi	a.		2 weeks
5	e exe ien al urial-l	E	resulting in death) Last	Due to (or as a con 4)	que ce of):					
	The law requires that the death certificate be executed ste has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai		d						
Š	entific ding p	Med	IF FEMALE:	00- 11	100					
	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	aldeath 3□	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
5	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of a 9□ Unknown	oeatn 5∟	Other (specify)				
Ľ	that the by ed by detac		Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Ŝ	uires sign id be	d by						1 □ Y€	es 2 □No 3 □ Pr	obably 4. Striknown
5	w req	lete						24a. Was a	n 24h Were au	Itopsy findings available
ב ב	he lar e has ige 2	Completed						autops	y pnor to death?	completion of cause of
<u> </u>	in: T ificet or, pa	ပိ	25. Was case referred to medical				26 Place of Doc	1 ☐ Yes 2 ath (Check only on		2□ No
>	/sicia s cert direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpatien	t 3 DOA Oth	00		ence 6 ☐ Other (Spe	cify)
5	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				w injury occurred	5,
5	ndin ath. r: Aft e fun	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigation		Injury		Yes 2 □ No			
2	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not to determined			eet, factory, office		28f. Location (St City or Town	reet and Number or Ru	ural Route Number,
5	Ital o rs aft al Di led in	Çer								
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 1 2 Medical Exa	nysician: To the best of my knominer: On the basis of examination	owledge, death ation and/or in	occurred at the tir	me, date and place	, and due to the ca	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	the the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	٠,	9d. Date sign#d (Mont	h Day Year)
)	Z = 2 S		1/ D	4		230. 610013	3584	8 '	H /14	INC
			30 North and I was	normal of the state of the stat	m 02c) (7	Deint)	000		/ / / /	21224
			30. Name and address of person who	To the To	23a) (1ype,		le Ferse	Hun	Gambo	: 11, mm
þ	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature			-	J 60 7 1/1	, , , ,
	Registr		APR 202	JUD DE SEE L	7					

			1 - For Stete Registrer	ate of Maryland		artment of tificate of			giene Reg. No.	06	14317
	Physici		1. Decedent's Name (First, Middle, Last) Laurice Hanna Mo	rcos			-	2. Date of Dea Month April		O6 ^{Year}	3. Time of Death 7:20 p M
ž	/Medic Examir		4a. Facility Name (If not institution, give street Washington Adventis			4b. City, Town, Takoma	or Location of Dea Park	th		nty of Death	
	Funeral Director		5. Social Security Number 6. Sex 132-34-0221 1□ M	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birt (Month, Da Aug. 1	year) 3, 1928	9. Birthp Cour Jer	place (State or Foreign ntry) usalem
	e Maryland 3a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery		, Town or Lo Cakoma						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?
36	be filed within 72 hours after death with the Maryland la Hyglene. d other than "netural", or Iteme 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1 If	venue, #703 Vas Decedent Ever in U.S rmed Forces? ☐ Yes 2 ☑ No 'Yes, Give 'ear or Dates:	ı	20912 Was Decedent of f Yes, specify Cu 1□Yes 2√2 No	Hispanic Origin? (ban, Mexican, Pue o <i>Specify</i> :	Specify Yes or No no Rican, etc.)	В	ace - Americ lack, White, cify: Whi	etc.
1215-0036	within 72 hou ene. than "netura he Madical E	Completed	15. Decedent's Education (Specify only highest grade con	n	(Give life. L	DO NOT use retir	e during most of wo	-	16b. Kind of		
	filed wil Hygien other th	Con		4	Admi	nistrati	ive Assis			ign Af	fairs
Maryland 2		To Be	17. Father's Name (First, Middle, Last) John Morcos					eh Laura		ame)	
	es 1 and 2 should of Heelth and Me fitem 27 is mark r other treumatio		19a. Informant's Name/Relationship (Type, F Yvette Morcos/ Siste	er	7333	New Han	npshire A	ve., #70			rk, MD 2091
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)	val from State ce	metery, cren	sition (Name of natory or other pi ven Cemete	Apr	Date il 22, 006	20c. Locatio Silver		own, State .g, Maryland
Balt	permit. Pages Depertment of important: If if eny injury or once.		21. Signature of Funeral Service Licensee	lo			ersity Bl				, MD 20901
8760,	certificate be executed American and India physicien and India phy	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of the consequence of t	ence of):	Smca Ax	monia phlopat ast	ly			
.O. Box 6	death certifi e attending I id for use as	by Physician/Me	in the past 12 months?	yes, outcome of pregnan □Live birth 2 □ Fetal □ Pregnant at time ot de □ Unknown	death 3	Ectopic pregnan Other (specify)	icy			Date of delive	ery Day Year
rds, P	quires that the de n signed by the a uld be detached f	d by Pl	Part II. Other significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions contributions to the significant conditions conditions to the significant conditions conditions to the significant conditions conditions conditions to the significant conditions cond	nting to death but not result the lites	lting in the u	nderlying cause o	given in Part I.	- 1	obacco use co ∕es 2 ⊠ oNo		he cause of death? pably 4 Unknown
Vital Records,	ysiclan: The law requires that the is certificete has been signed by th director, page 2 should be detached.	Completed	hyperter	Sin				24a. Was autor perfo 1 Yes	rmed?	b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
Vita	iclan certific	å	25. Was case referred to medical examiner?	tal:		10	thor	eath Check only o			
Division of	ling Ph After th uneral	ation: To	T Tes 2 K NO	1 inpatient 2 L	ER/Outpatien 28b. Time of Injury	28c. In	4 Nursing	Home 5 Resid			(v)
Divis	지 문 는 C	Certification:	3 County 6 Could not be	Be. Place of Injury - At hor building, etc. (Specify)	me, tarm, str	eet, factory, offic	6	28t. Location (City or Tox	Street and Nu wn, State)	mber or Run	al Route Number,
	To the Hospital of within 24 hours at To the Funeral Completely filled it	edicai	(Check only 2 Medical Exeminer:	n: To the best of my know On the basis of examinati and manner stated.							
)	To the To the complet	Σ	29b. Signature and three of certifier	Sign	? _	29c. Lice	UJ66	1010	29d. Date sig	ned (Month,	Day, Year)
	1		30. Name and address of person who comple	eted cause of death (Item	23a) (Type	LN,	IEU !	302	e,	10	20710
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 1 2006	32. Registrar's Signati	y de	ode	,		,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $1^{D_{av}}$, Month Physician 2006 April 11:23AM EARLMOORE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Prince George Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Mar. 14, 1936 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1**X** M 2□ F Maryland 70 Director 213-34-2827 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once. 10b. County 1 ☐ Yes 2 ☐ No Directo Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 U.S.A. 1372 Limit Ave by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ X es 2 □ No 1958 -If Yes, Give Year or Dates: 1969 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Guard Elementary/Secondary (0-12) College (1-4or 5+) Armory Caretaker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Millard Lulu Dorsey Moore ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1372 Limit Ave Baltimore, MD 21239 Lena Moore- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cem 4/21/06 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service Licensee Rockville, MD20850 246 N. Washington St V2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ certificate has been sign rector, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 □ Impatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 1 No nours after death.

neral Director: After this
/ filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006d, 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, Munde Grant Filed (Month, Day, Year) 1 7503 Surratts Rd Clinton, 31. Date filed (Mor State Registrar

		For State Registrar		partment of Healt ertificate of Dea	th	Rag. No.	14319
Physicia	an	1. Decedent's Name (First, Middle, Last) Malaki Issa	Masoud		2. Date of Month	Day Vo	3. Time of Death
/Medic	A					1 16, 2006	11:30 P M
Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Locat		4c. County of I	
	9-	9315 Willow Creek		Montgomery If Under 1 Year If Un			gomery
Funeral Director		210-92-3002	x 7. Age (In yrs. last birthda ∂M 2□F 93 Yrs.	Months Days Hou	rs Min. (Month,	Birth 9. Day, Year) 4, 1912 Je	Birthplace (State or Foreign Country) rusalem
and *	}	Usuaf Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
within 72 hours after death with the Maryland ene. Than 'natural', or Itema 23e or 28e-f show Ite Medicel Examiner mad be notified at	'n		7.5				1 □ Yes 2X□ No
28a-	Funeral Director	Maryland Montgome 10e. Street and Number	ery Mc	ontgomery Vil:	rage	10g. Citizen of Wha	t Country?
with so or	ā	9315 Willow Creek	r Drivo Ant B	20886		US	
eath Da 23	era	11, Marital Status			Origin? (Specify Yes or		American Indian,
lterr Dec	Ë	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	 Was Decedent of Hispanic If Yes, specify Cuban, Mex 	kican, Puerto Rican, etc.)	Black, \	White, etc.
rs ar	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Spe	city:	Specify: W	hite
tura	Completed by	15. Decedent's Edu	ucation 16a Dec	cedent's Usual Occupation		16b. Kind of Busin	ess/industry
in 72	plet	(Specify only highest grad	le completed) (Gi	ve kind of work done during : b. DO NOT use retired)	most of working		
the ene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	notype		Pri	nting
Hyg Hyg other	O	17. Father's Name (First, Middle, Last)	'	18. M	lother's Name (First, Mide	dle, Maiden Sumame)	
d be antal	To Be	Issa Masoud			Rihan Unk	nown	
nd Me	F	19a. Informant's Name/Relationship (7)	vpe. Print) 19b. Ma	ailing Address (Street and Nu	ımber or Rural Route Nur	nber, City or Town, Sta	ite, Zip Code) MD 208
d 2 s th an trau trau		Tarize Masoud/ Da		5 Willow Cree			
Heal Heal		20a. Method of Disposition	20b. Place of Dis	sposition (Name of	Date	20c. Location - Cit	y or Town, State
at of the second		ty⊡ Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemetery, c	rematory or other place)	April 22,		
tmer tant njury		4 □ Donation 5 □ Other (Specify)	1	Heaven Cemetery	1		ring, Maryla
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I important: If them 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		A2aNarejagd Addiesach 500 University			
anth certificate be executed attending physician and for use as the buriat-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arteriosclerotic Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.				
that the death certification by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date o	•
t the	hys	9 Unknown	9□ Unknown				
requires that the een signed by th rould be detache	by P	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in P	art I. 23e. D		ite to the cause of death?
w require been sig should b	ed 1				1	Yes 2 No 3	☐ Probably 4 ☐Unknow
× 0 %	Completed				24a. W		re autopsy findings availab
9 L 9	mc				pe	erformed? dea	
ician: Th certificate rector, pag	Ö	25. Was case referred to medicaf			l ∐ Ye Place of Death Check on		Yes 2 No
	00	examiner?	Hospital:	Othor	Nursing Home 5 XR	-	(0(-)
Phys	: To	27. Manner of Death	28a. Date of Injury 28b. Time	TIGHT 3L DOA 4L		oe how injury occurred	Specify)
ding Ph th. After thi funeral	tlon	1 XNatural 5 Pending	(Month, Day Year) Injur			. ,	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At home, farm, building, etc. (Specify)		28f. Locatio	n (Street and Number Town, State)	or Rural Route Number,
Hospita 24 hours Funeral etely filler	edical C		rsician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.				
ompl	Me	29b. Signature and title of certifier	().)	29c. License num	ber	29d. Date signed (/	Month, Day, Year)
- s - 0		· 0	m.o (cme)	D15236		April 20,	2006
4							
1		30. Name and address of person who carl I. Margolis,		oe,Print) 'ille Pike, #2	211, Rockvil	le, MD 208	52

		1	For State Registrar		f Marylar	nd / Depa		of H				iene _{g. No.}	US	14320
		400	Decedent's Name (First, Middle	e, Last)						2	2. Date of Deat	h Day	Year	3. Time of Death
	Physicia		Carolyn Mary	MacMul	.1an						April	19, 2	006	6:00 P M
	/Medic Examin		4a. Facility Name (If not institution Corsica Hills	n, give street and nu	mber)			Town, or ervi	Location of	of Death			nty of Death	
	Funeral Director		5. Social Security Number 425-12-8723	6. Sex 1 ☐ M 2 🙀 F	7. Age (In yrs.	last birthday) 35 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day) 11y 30,	1920	9. Birth Cou Miss	nplace (State or Foreign unity) SISSIPPI
	death with the Maryland ma 23a or 28a-f show	ctor		Anne's		ty, Town or Lo	11e					Og Citizon	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🖺 No
	ith the	Dire	10e. Street and Number)			10f. Zip	1666				USA	or what out	
	ath w	la l	512 Victoria D		and and Francis I	10 12				igin? (Spec			Race - Amer	ricen Indian,
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or liema 53a or 28a-f show event, the Medical Examenar must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 Tyes	2≹ No ive		If Yes, spe				ify Yes or No- ican, etc.)		Black, White	
0500-617	within 72 hours after ene. than "natural", or Ite to Medical Examina	ted	(Specify only highe	nt's Education est grade completed)) (1-4or 5+)	(Give	dent's Usu kind of wo DO NOT u	rk done d	<i>duri</i> ng mos	st of working	g		of Business/I	,
4	with iene.	mo	Elementary/Secondary (0-12)	4	(1-401 5+)	Se	creta	ry				Fede	ral G	overnment
מומ	permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'n any injury or other traumatic event, the Medical Conce.	To Be C	17. Father's Name (First, Middle, Charles Edward		Sr.						(First, Middle, cLaurin		mame)	
Baltimore, Maryland	d 2 shou th and M 7 Is mar traumati	-	19a. Informant's Name/Relations Charles Edward		TT	19b. Maili 215 L	ng Address OWMAI	(Street a	and Numb	er or Rural ridge	Route Numbe port, W	r, City or To	own, State, Z 330	Zip Code)
ore,	es 1 an of Heal if item 2 or other	li	20a. Method of Disposition 1 Burial 2 □ Cremation		20b.	Place of Dispe	matory or t	ther plac	(8)		2,2006		ion - City or	
	artment ortant: injury		*4 □Donation 5 □ Other (\$21. Signature of Fundamental Service	Specify)	FOI						z,2006 ph Gaw1			
מ	Depo Impo		> Akothi	1000		51	.30 W	scor	sin .	Ave.	N.W., W	IDC 2	20016	
	Physician /Medical Examiner		23a. Parl 1. Enfer the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_a. (A	each line.	afcolo	n, ma	tasta	tio fo	golv	is and	Tungs		Approximate Interval Between Onset and Death
1/e0,	*	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	o (or as a conse									
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live	utcome of pregi birth 2 Teg gnant at time of snown	tal death 3	□Ectopic p		/			230	I. Date of del Month	livery Day Year
ds, P.	uires that the signed by		Part II. Other significant condit	tions contributing to	death but not re	sulting in the	underlying	cause giv	en in Part	:I. 		obacco use res 2 🗆 I		o the cause of death?
Division of Vital Records,	he law requin e has been si ige 2 should	Completed by	Hypertensite	n							24a. Was autop perfo		24b. Were au prior to death?	utopsy findings available completion of cause of
g	ficat or. pi	Ö	25. Was case referred to medic	al					26. Plac	ce of Death	(Check only o			
of VI	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 28a. Dat	Inpatient 2 le of Injury	ER/Outpatie	of	OA Ott	ry at		ne 5 🗌 Resid 28d. Describe t			ocify)
vision	Attendin ar death. ector: Aft by the fur	Certification:	3 ☐ Suicide 6 ☐ Coule	stigation d not be 28e. Place	ce of Injury - At	home, farm, s	M		Yes 2		28f. Location (3 City or To	Street and I	Number or R	ural Route Number,
ō	the Hospital or A hin 24 hours after the Funeral Dire		Continu	ing Physician: To a	to best of my k	nowledge des	ith occurre	at the ti	me, date a	and place, a	and due to the	cause(s) a	nd manner as	s stated.
	To the Hos within 24 hd To the Fun completely	Medical	(Check only 2 Medice one)	el Examiner: On the	basis of examination stated.									
}	To 1 To 1	Σ	29b. Signature and title of certif	WWIN W	Mey	MI	25	.c. Licens	1725	433		4	4.20	0.06
	5		30. Name and address of person	0 11100	iuse of death (It	em 23a) (Type	Print)	Inc	Lam	e. Ea	ston.	40 2	21601	
	St Regis	tate trar	31. Date filed (Month, Day, Yea		negistrar's Sig	nature	parte	9	-07		ston,			

		1 - For State Registrar			artment of He rtificate of D		A	eg. No.	14321	
Dhuaiai		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	3. Time of Death		
Physic /Medi		Nancy M. MacK					April 14,2006		0900	
Examir	ner	4a. Facility Name (If not institution, give	а		4b. City, Town, or			4c. County of Death		
		Sunset Ridge				erick, Md		Frederick		
Funeral Director			7. Age (in)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Ct. 27	Year) 1922 No	Birthplace (State or Foreig Country) ew Jersey	
A TI		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Le	ocation				10d. Inside City Limit	
	ō	Md County	Frederick						1 X Yes 2 □ N	
288	rec.	10e. Street and Number		10f. Zip Code			1	l0g. Citizen of What	Country?	
3a o		7021 Rock Creek Drive			2170)2	U.S.A.			
ms 2	by Funeral Director	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto			ecify Yes or No-		
or Ite	Ī	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give			Specify:				
2	t by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 □ Yes 2 X No	Зреспу.	<i>Specity:</i> _W		Specify: White Kind of Business/Industry	
dicut	Completed	15. Decedent's Ed (Specify only highest grad			edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)		ng	16b. Kind of Busine		
Man.	npl	Elementary/Secondary (0-12)	life.	DO NOT use retired)						
ygier th			4Years +	Regis	stered Nur		1571-1-4-3-67-6-01-	Nursing		
If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exactinat mast be notified at	To Be	17. Father's Name (First, Middle, Last) Dr. Michael Josep	h Coffey			18. Mother's Name Anna Bri		Maiden Sumame)		
and N Is ma		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street a	nd Number or Rura	l Route Number	r, City or Town, Stat	e, Zip Code)	
alth a 27 is er trau		Candace M. Rollin	-		3 Van Ness		Vashing	ton, Md.	20016	
of Herr I therr		20a. Method of Disposition 1 ◯XBuriał 2 □ Cremation 3 □	Domewal from State	b. Place of Dispo cemetery, cre	osition (Name of matory or other place) D		20c. Location - City	or Town, State	
nent of int: If it iry or o		'4 Donation 5 Other (Specify	Hemovai nom State		ry Cemeter		/06 I	East Orang	ge, N.J.	
Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service tricenses 22. Name and Address of Facility ROBERT E. DATLEY & SON FUNERAL HUMES, P. A. 1201 N. Market St. Frederick, Md. 21701 Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death								
		23a. Part1. Enter the disease, or comp	fications that caused the c	death. Do not en	201 N. Mar ter the mode of dying	ket St. I , such as cardiac o	rederic respiratory arr	ek, Md. 21	L 70 1 Approximate	
		Immediate Cause (Final							A	
ysician Medical	П	Immediate dause (inlar disease or condition resulting in death) Due to (or as a consequence of):							lelay	
caminer		Sequentially list conditions,	b. Unsagsis			Incek				
si s	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a consequence of):						
and -tran	кап	that initiated events resulting in death) Last	U.	Due to (or as a consequence of):						
ysiclan and ie burial-transit	cal Examiner		,	state hyptensin					6 months	
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igned b be deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23a. Did to	bacco use contribute	e to the cause of death?	
n sig	g p						1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknow			
been si should I	Completed						24a. Was a	in 24b. Were	autopsy findings availab	
age 2	mc.							autopsy prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No		
ificat or, pi	e C	25. Was case referred to medical				26. Place of Death			95 28 190	
n. After this certificate has funeral director, page 2 a	To B	examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Othe			ence 6 Other (S	ipecify)	
er thi		27. Manner of Death	28a. Date of Injury	28b. Time o				ibe how injury occurred		
ir death. ector: After by the fune	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	M 407 407 407 407 407 407 407 407 407 407							
death.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injury - /	lace of Injury - At home, farm, street, factory, office uilding, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
after Dire		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
24 hours after Funeral Dire	73	,	una manner stateu.		29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)	
thin 24 hours after b the Funeral Dire impletely filled in b	Medical	29b. Signature and title of certifier					_	G		
within 24 hours after death To the Funeral Director: completely filled in by the	Medi	29b. Signature and title of certifier	- 1			1.47		A	2 - 01	
within 24 hours after To the Funeral Dire completely filled in b	Medi	VENT Cle	myer, f	MD	D57	647		April , 14	2006	
within 24 hours after To the Funeral Dire completely filled in b	Medi	30. Name and address of person who			D57		× 44 D		2006	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:30P M Ε. 2006 20, April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING AND REHAB. CENTER WORCESTER BERLIN, MARYLAND If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 💢 F Director 222-01-6799 MILLSBORO, DE APR 13,1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Director DELAWARE SUSSEX LAUREL 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16674 LAUREL ROAD 19956 UNITED STATES Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) AGRICULTURE College (1-4or 5+) LINE PROCESSOR 7TH GRADE MANUFACTURING other If itam 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental PHILLIP R. JOHNSON SALLIE WARRINGTON Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD J. MOORE (SON) 10013 TIMMONSTOWN ROAD; BERLIN, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CAREY'S CEMETERY APR 24,2006 MILLSBORO, DE Important: injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee WATSON FUNERAL HOME Part1. Enter the disease, or complications that days of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theoseleste **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o. 9□ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No certificate 1 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No. Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Netural 5 Pendina death. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Print) Cocartal Heden

State

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Moore

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31. Date filed (Month, Day, Year)

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	÷.		1 - State Registrar Americal Item #5 1. Decedent's Name (First, Middle, Last)	State of Maryland / D Per FII G855 5/					g. No.U U	5	3. Time of D	3 Death	
	Physici		CECELIA MAE O'SHE				Month APRIL	Day	Year 006	0704	М		
3	/Medio	21	4a. Facility Name (If not institution, give street and number)			Town, or L	ocation of Deat		4c. County of De				
		-38	ANNE ARUNDEL MEDICAL CENTER			NAPOL	IS		ANNE ARUNDEL				
	Funeral Director		212-22-6831	7. Age (In yrs. last birth	rs. If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 6 1	929	Coun	ace (State or try) LAND	Foreign	
1 215-0036 within 72 hours after death with the Maryland	he Maryłand 28a-f show	d by Funeral Director								od. tnside City			
	with		10e. Street and Number 611 OAKLAND HILLS	COURT APT 202	101. 21	21012			g. Citizen of W US		uy:		
9200	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, Ite Medical Exactinar mail Landillied at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Wold of If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 【▼No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
nd 21215-0036 e filed within 72 hours af al Hygiene. Lother than "naturel", or	ithin 72 ie. ien. "nei	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		ork done dui ise retired)	ring most of wor	king	6b. Kind of Bu				
	filed wi Hygien Sther th		12	0	SUPERV		O. Marthada Nad	no /First Middle A	TELEPH		OMPANY		
yland	should be fill nd Mental H marked off umatic ever	To Be	17. Father's Name (First, Middle, Last) CECIL S. JENKINS					ne (First, Middle, M EOGHEGAN	aiden Sumam	Θ)			
Mar d 2 sh	nd 2 sho alth and 27 is mu r trauma		19a. Informant's Name/Relationship (Type DAWN O SHEA/DAUGHT		-			one Number, ODENTON			Code)		
	ages 1 a ant of Hei at: If Item y or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	comoton	Disposition (Na y, crematory or	other place)	V 1.12	Date 2 6/2006	Oc. Location -			MD	
Baitir	permit. Pages 1 an Department of Heal Importent: If Item 2 any Injury or other ones.		21. Signature of Funeral Service Licensee		22. Name a	nd Address	of Facility LFENBE I	N & NEWNA	CAMBRI M FUNE MD 2	RAL E			
/Medi Exami	Physician // Medical Examiner and provider and the pringing and the pringing and the pringing and the pringing and the principal and the p	Ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
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	quires that n signed b uid be deta	Completed by Pt	Part II. Other significant conditions control	buting to death but not resulting in the underlying cause given in Part I.			23e. Did tob	tobacco use contribute to the cause of death? Les 2 \[\sum \text{No} \] No 3 \[\sum \text{Probably} \] 4 \[\sum \text{Unknown} \]					
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VIT 3	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: Other									
on of Jing Phys	nding Physiclan: ' ith. : After this certifica s funeral director, p	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T		28c. Injury at Work? 28d			te 5 Residence 6 Other (Specify) 8d. Describe how injury occurred				
Division	or Atter or Atter after dea Director in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospital 24 hours Funaral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the within 2 To the complet	Me	29b. Signature and title of cartifier 29c. License number 29d. Date signed							(Month.	Day, Year)	Miles of	
2	5-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								7		
1	Sta Regist		31. Date filed (Month, Day, Year)	32. Figistrar's Signature	And	VI) 1-1	7 17	V V)	11) 5) 6	(1) 1119		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:20 PM Gerald Wayne PETERSON April 231 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept.12,1945 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 60 215-42-3074 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
and it if team 23 a or 28e-1 ehou ant: if team 23a or 28e-1 ehou ant: if team 20 or other traumatic event, is the libral Expirit at must be codified at 1 ☐ Yes 2X No Maryland Washington Hagerstown Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 USA 14541 Marsh Pike Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) painting 10 house painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Harold Peterson, Sr. Leona Rvder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14541 Marsh Pike, Hagerstown, Maryland 21742 Patsy Peterson - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 2002 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/25/06 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician ostenor panch resulting in death) /Medical Due to (or as a consequence of): Examiner pinehon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Respons Lan Due to (or as a consequence of): Box 68760. Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes : After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဂ္ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of beath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Cert floation: 28c. Injury at Work? 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: . completely filled in ty the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai 1 Conflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maximar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62588 April 24th, aoua, NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hegerstown, Street 251 E. Antichem VH-10 MISAOUA JUPITH 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 25

ORIGINAL

06-02820 Carl Pierce

Please Type or Print in Black Indelible Ink
State of Manyland / Department of Health and Mental Hygiene

		- For State Crivial yiand / Department of Health and Wentar Fig.	Reg.	No 2006	1323
Physicia	n/	1. Decedent's Name (First, Middle, Last)	Date of Death Month D	av Year	3. Time of Death
Medical Examir		Carl Fierce	April 26, 200	06	0802 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8784 Black Dog Alley Easton		4c. County of Deat Talbot	
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth(thplace (State or
Funeral Director	2	220 -76-1623 1 MM 2 F Hours Min.		Forei	
ow any		10a State 10b. County 10c. City, Town or Location MD TAIDOF EASTON	·		10d. Inside City Limits 1 Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e, Street and Number 10f, Zip Code	10g.	Citizen of What Cou	
with the		8)84 Black DOG Alley 2/60/ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.			ican Indian, Black,
ter death	/ Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year Armed Forces? 1 Yes 2 No 1 Yes 2 No specify:	Rican, etc.)	White, etc.	IACK
2 hours af "natural	ted by	15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		6b. Kind of Business	Industry
215-0036 be filed within 72 ntal Hygiene ked other than '	ompleted	12th grade Custodian	(First, Middle, Mai	hesupa	ake Center
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene important: If item 27 is marked other than injury or other traumartic event, the Medical	BeC	Charles mealy Vale	ries	12/ec/4	
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental lant: If item 27 is marked or other traumatic event.	۵[turloca		2/6/3
2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, grematory or other place)	5/5/x	Location - City of	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	engiè	5m Hh	Fired Home
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	or respiratory arrest	, shock, or heart	Approximate Interval
Wedical xaminer	Ì	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ior descend	ing cornary	Between Onset and Prtery Death
		Sequentially list conditions, b.			
(1	aminer	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last underlying indeath.			
760, icate be executed g physician and the burial - transit	<u>ш</u>	d. 3+cm#/230 77 novMV 6956 6/20/06 TT		=	
60, ate be e: ohysiciar	Medical	UNICHOED INCIDED		23d Date of deliver	<u> </u>
Ox 6876 sath certificat attending ph or use as the	sician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnate at time of death	ancy		y Day Y ear
Box 687 re death certification the attending red for use as t	Physic	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. E ires that the d signed by the	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		acco use contribute to	the cause of death? bably 4 Unknown
Division of Vital Records, P.O real or Attending Physician: The law requires that its after death al Director: After this certificate has been signed be led in by the funeral director, page 2 should be deated.	Completed		24a Was an autopsy	prior to	utopsy findings available completion of cause of
tal Reco cian: The law certificate has	Com		performe 1 ✓ Yes 2	ed? death?	es 2 No
Vital Rec ystcian: The his certificate	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing		esidence 6 🗸 Othe	
n of Vi ding Physi After this funeral dir	£	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how		
ion c tending eath tor: Af	ţį	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No			
Division piral or Attent ours after death teral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stre or Town, Stat		ural Route Number, City
in in in in in in in in in in in in in i		4 Homicide			
To the How within 24 h	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner etated. 29b. Signature and title of certifier 29c. License number		a place, and due to t	
		O.C.M.E.		April 27, 2006	
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201		
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 0 3 2006 32. Registrar's Signature			

		For State Registrar	State of Man	yland / Depa <i>Cei</i>	artment of H <i>rtificate of I</i>	lealth and N Death		giene	106	14326
re.	51	Decedent's Name (First, Middle, Last)				2. Date of Dea	ith		3. Time of Death
Physicia		Freda Grace	Rainhau	becher			Month	Day 18	Year	5:10 A M
/Medic		4a. Facility Name (If not institution, give		pecher		Location of Death	7		inty of Death	
Examin	er	. 0	0 1		P	LOCATION OF DOCUM				2.1
	100	5. Social Security Number 6. Se	K Dad	n van (nat birth da A	If Under 1 Year	If Under 24 Hrs.	0. Data of Birth		2000	
Funeral		15	M 201	n yrs. last birthday) C/_ Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		Cou	place (State or Foreign intry)
Director		Usual Residence of Decedent		86 Yrs.			3-29	- 20	Mar	yland
and **		10a. State 10b. County	10	Oc. City, Town or Lo	cation				T	10d. Inside City Limits
laryli sho	5			Frantsvill						1 ☐ Yes 2 No
Ne N	ect	MD Garrett		cancsviii						
vith t	Director	10e. Street and Number			10f. Zip Code			•	of What Cou	intry ?
672.15-UU36 within 72 hours after death with the Maryland jiene. rthan "netural", or iteme 23a or 28a-f show the Medical Example minest be motified at	Funeral	2540 Pigs Ear Rd.			21536			USA		
r de	rue	11. Marital Status	12. Was Decedent Eve Armed Forces?	ir in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	
or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 X No	Specify:		Soe	acify:	
ours ours	d by	3 Nidowed 4 Divorced	Year or Dates:						Whi	ite
275-UU36 thin 72 hours aft e. an "netural", or Medical Exam	ete	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of	during most of work	ing		of Business/Ir	
F e thi	npl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	eria Wor	1)			ett Cou	-
1d Z1Z13- s filed within 72 t Hygiene. other than "nel	Completed	8		Carec	eria wori	7.E.L	İ	30ard	of Edi	ucation
	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sun	пате)	
Iryian should be nd Mentat marked o	2	Harry Bowser				Reba Smit	:h			
Iaryia 2 should and Men is marke eumatic		19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Numbe	r, City or To	wn, State, Zi	ip Code)
2 5 E S		Judy Schlossnagle/	Daughter	3810 1	West Garf	ield Rd.	, Columb	iana,	OH 4	14408
S 1 a		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place		Date	20c. Locati	on - City or T	own, State
age age of the part of the par		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Addison Co			21, 200	6 Add	dison,	PA
Baltimore, permit. Pages 1 ar Department of Hea Importent: if item eny injury or othe		21. Signature of Funeral Service Licens			. Name and Addres	ss of Facility N	auman Fii	neral	Homes	P.A.
Dep Dep Dep De De De De De De De De De De De De De			man		P.O. Box				21536	
									21300	Approximate
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Physician		Immediate Cause (Final disease or condition	, Adev	no Caro	MOME	a Colo	u me	ES 19	515	inear
/Medical		resulting in death)	Due to (or as a co	onsequence of):				LIVE	5	
Examiner		Sequentially list conditions	b							
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cuter	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
U, lexe en ar	EX	resulting in death) Last	Due to (or as a co	onsequence of):						
Na rbu, cate be executed physicien and the burial-transit	dical	•	d							
	ed									
BOX lath cert attendin for use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		-			23d.	Date of deliv	very
death atte	cia	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 2 ☐ 4 Pregnant at tim		Ectopic pregnancy Other (specify)				Month	Day Year
.C. BOX 6 the death certifi y the attending i	Physician/Me	9 Unknown	9□ Unknown							
that the death certified by the attending detached for use as		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use o	contribute to	the cause of death?
S & & S	d by						1 🗆 Y	es 2□N	o 3 Pro	bably 4 Unknown
Kecord he law require has been si sge 2 should I	Completed									
ec faw las b	npl du						24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
	Son						perfor 1 ☐ Yes	2KINo	death? 1 ☐ Yes	2 🗆 No
VITAL siclan: T certificat rector, pa	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	n <i>e)</i>		
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g Phy grhy er this		27. Manner of Death	28a. Date of Injury (Month, Day Yo	28b. Time of	28c. Injun Worl	y at	28d. Describe h	low injury oc	curred	
nding F th.: After e funer	at lo	Pending 5 ☐ Pending investigation	(Month, Day 16	ear) Injury		Yes 2 □ No				
DIVISION Tor Attending after death. Director: Afte	flo.	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, str	eet, factory, office		28f. Location (S	Street and N	umber or Rui	ral Route Number,
Ting after	Certification:	4 Thomicide	building, etc. (Specify)	•		City or Tow	m, State)		
UNISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier Certifying Phy	sician: To the best of m	ny knowledge death	occurred at the tin	ne, date and place	and due to the	cause(s) and	manner as	stated.
24 h Fur stely	Medical	(Check only 2 Medical Exami	ner: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death occur	red at the time, o	date and pla	ce, and due	to the cause(s)
o the	Me	29b. Signature and title of certifier			29c. Licens	e number	1	29d. Date si	gned (Month	. Day, Year)
FRES		D 0 . N	Du.	100 Des	1112	6104		U	1 .	20/19
,		r ruce wen	mes Im		110	W(3)			1	8100
10		30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type,	SWU1	Λ 2	I) A	Id.	- A An	A h 1 1000
-		31. Date filed (Month, Day, Year)	32. Registrar's		7001	neres	1100	Mar	ra M	179170
Sta		31. Date filed (Month, Day, Year)								

			1- For Amend #10b, 1	State of	Maryland/ x101 per/	Pepa Cei	atment o	f Health of Deat	n and N th		giene Reg. No.	06	14327
	DI		1. Decedent's Name (First, Middle, Las					-		2. Date of De.	ath Day	Year	3. Time of Death
	Physici /Medic		JANE	REAT)					4.	-21-	06	5-25 AM
1	Examin		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City, Tow	n, or Location	on of Death			nty of Death	
			Carroll Hospital (Ama (In um In at t	h (a b a d a)	Westm:	inster	ler 24 Hrs.	0 D(D)		rroll	
	Funeral Director		5. Social Security Number 6. S 040–12–4334	_M 24€0 F	. Age (In yrs. last b 86	Yrs.	Months Da			8. Date of Bird (Month, Da Oct. 1	y, Year)	Conn	place (State or Foreign intry) Lecticut
			Usual Residence of Decedent		00					000. 1.	+,1919	COIIII	ecticat
	ylenc		10a. State 10b. County	rroll	10c. City, To	wn or La	cation	aneyto	own				10d. Inside City Limits
	e Ma	cto	Maryland Frederic		Freder	ick							1 XYes 2 No
	or 28	Directo	10e. Street and Number 100 And	crim BLV	D		10f. Zip Cod	de			10g. Citizen	of What Cou	ntry?
	23a		1774 Valley Side I				2170		1787		United		
	er de item	Funeral	11. Marital Status	12. Was Decede	es?	13.	Nas Decedent f Yes, specify (of Hispanic (Cuban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Americ Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 If Yes, Give Year or Date			1□Yes 2덨	No Speci	ity:		Spe	city: Whi	ite
21215-0036	within 72 hours after death with the Marylend ene. then "neturel", or iteme 23a or 28a-f ehow then Madical Exeminer must be notified at	ted	15. Decedent's Ed	ducation		a. Dece	dent's Usual Do	ccupation			16b. Kind o	f Business/In	ndustry
215	hin 7.	ple	(Specify only highest gra	College (1-4	for 5+)		kind of work do DO NOT use re		ost of work	ing		_	
C	filed with Hygiene. other ther	Completed		2		Home	Maker				Own	Home	
		Be (17. Father's Name (First, Middle, Last)							e (First, Middle,		iame)	
yla	2 should be a and Mental in marked o	၉	George Cowperthwa:		0.					Fernand			
Nar	s 1 and 2 should f Health and Mer ttem 27 is marks other treumatic	7 1	19a. Informant's Name/Relationship (1					al Route Numbe			o Code)
	1 end Heelth em 27 ther tr		Patricia Read Barr	ihart/Dau			nhart Ki sition <i>(Name o</i>		1	ter, MD		on - City or To	own State
סר	Pages Int: If it		1 ☐ Burial 2 【XCremation 3 ☐		ate cemel	tery, crer	natory or other Crema	place)	1				Maryland
Baltimore,	it. Partiment		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licen		Trede				4/24/	0.0			
Ba	permit. Pages 1 end 2 Depertment of Heelth a Important: If trem 27 is eny injury or other tree		> Brodley &	Strat		16	521 Opo	ssumto	wn Pi	uffer F ke, Fre	derick		
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cau one pause on eac	used the death. Do th line.	o not ent	er the mode of	dying, such	as cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
7	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a52	EPS15								Cristi and Death
1	/Medical Examiner		Tooding in Journ,	Due to (or	APHY LO	e of):		. AU	RF-U	< /FL	Lin LI-	TIS	
п		<u></u>	Sequentially list conditions,	0.	as a consequence		CCUQ	, ,,				/	
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9	ng ph	Jed	IE EENALE.										
Вох	eeth certific ettending p for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy h 2 Fetal dea	th 3	Ectopic pregna	ancy				Date of delive	
	at the dee by the et tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnan 9□Unknow	nt at time of death	5 🗆	Other (specify	/)				Month	Day Year
P.0	that th ed by detacl		Part II. Other significant conditions of	ontributing to dea	th but not resulting	in the u	nderking cause	a given in Pa	rt I	23e Did to	obacco use c	ontribute to t	he cause of death?
of Vital Records,	ires tha signed d be de	þ	DIABETE	5 m	ELUT	45	identying cause	giveniinra	,,,,	1 🗆 1			bably 4 [Unknown
Ö	w requir been si should I	etec	PERIPHE	RAI	MASCA	111	ar D	15EA	-55				, –
3ec	has has	Completed	PETITION	7,0	0/15		114 1			24a. Was autop oerfo		prior to co death?	opsy findings available empletion of cause of
<u></u>	n: The I ficete ha	e Co	OF Manager referred to medical							1□ Yes	2 No	1 🗆 Yes	2 No
₹	slcian: certifice lirector, p	8	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: Inp	patient 2 ER/C	Outpation	t 3 DOA	Othor		h <i>(Ch</i> ec <i>k only o</i> me 5 ☐ Resid		Other (Cons.)	L.)
of	ng Phys fter this neral di	ر ان	27. Manner of Death	28a. Date of (Month,		. Time of		Injury at Work?		28d. Describe h			у)
<u>o</u>	nding I sth. r: After e funer	atio	Natural 5 Pending Accident investigation		Day Year)	Injury		Work? 1 ☐ Yes 2	□No				
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Ö	ital or rs afti al Dir	Certification:		Juliung	,, 2.2. (0,000,7)					ony or row	, 5,4,0)		
	To the Hospital or Attending Pl within 24 hours after deeth. To the Fundral Director: After completely filled in by the funera	Medical	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the be niner: On the bas and manne	est of my knowledges of examination a stated.	ge, death and/or in	occurred at the restigation, in n	e time, date ny opinion, d	and place, leath occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due to	tated. o the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier			~		ense numbe			29d. Date sig		
			Dan		-60			3021	63		04	-21-0	26
	Ó		30. Name and address of person who		of death (Item 23a) (Type,	Print)			200	men	ORIAL	AVENUE
			FRANCIS EHOU	MD	CARRO	oll	HOS IT	AL CE	LVTES	· WE	STMI	USTER	AVENUE MD ZIIS
Ī	Sta Registr	_	31. Date filed (Monting RYez) 4	2006 ^{32. R}	istrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2006 ear April 22, **Physician** 12:30 P M LILLIAN ROGERS MYRA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF 92 October 23,1913 Pennsylvania 181-22-3205 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturet", or freme 23a or 28e-f ehow any injury or other traumatic event, its Modical Exempler must be notified at once. 1 ☐ Yes 2 X No Maryland Washington Hagerstown Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1008 Valleybrook Drive 21742 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 27 No Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank J. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1008 Valleybrook Drive, Hagerstown, Md. 21742 Mary E. McPherson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) William Penn Cemetery 05-01-06 Philadelphia, Penna 21. Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, R. hoel 21740 Md. 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumoniz tera. **Physician** a /Medical Due to (or as a consequence of): Examiner tall piratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Reinz 0 and that initiated events resulting in death) Last Due to (or as a consequence of): physicien Physician/Medicai m an 22 as the IF FEMALE: US6 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by pe q 2 PNo 3 Probably 4 Unknown TVIZ 5 ertensia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 mp/ant certificate K SINUS 2 No 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred dedical examiner? Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 No 4 Nursing Home ٩ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After Injury Division s after dea. 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel within 24 hours a To the Funeral I 1 (Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

13H-10

Box 68760.

P.O.

State Registrar 31. Date filed (Month, Par Year)

FRancisco

HOSPITBUIST

251 Daniel DO 32. Registrar's Signature

/Wash. CNTY Hosp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AniiPTZM ST.

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State of Maryland / Department of Health and Mental Hygiene | | |

and religion and the	4	3	2	0
	- 1	100	D Apr	-

				Cert	ificate of	Death		Reg. No.	3 17062
	8 1 - 223-22	1. Decedent's Name (First, Middle, Las	t)				2. Date of De		3. Time of Death
*	Physician /Medical	Evanna Co	onnor RIDGEL	LY			14	33 3	006 4.12 AM
	Examiner	4a Facility Name (If not institution, give	street end number)			4b. City, Town, or l			
		Julia Manor			Hillarder d Venu	Hagersto		Washir	0
	Funeral Director	214-09-2030	ex 7. Age (In y	rs. lest birthday) 88 Yrs.	If Under 1 Year Months Deys	Hours Min.	8. Date of Bir (Month, Da Aug. 2	, 1917 M	B. Birthplace (State or Foreign Country) 1aryland
	pug *	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loca	ation				10d. Inside City Limits
	Aeryti Paho Pa	Maryland Washingt		lagerstow					14 Yes 2 □ No
	the 188	10e. Street end Number		14801000	10f. Zip Code			10g. Citizen of Wh	at Country?
	ath with	1024 Lindsay Lane			217			U.S.A	A. American Indian,
21215-0020	iges 1 and 2 should be filed within 72 hours efter death with the Meryland it of Health end Mental Hygiene. If item 27 is marked other than "satural", or items 23s or 28s-f show or other traumatic event, its Medical Examinat must be norified at or other traumatic event, its Medical Examinat must be norified at To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of t Yes, specify Cub ☐ Yes 2점 No	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		White, etc. white
5	72 h	15. Decedent's Ed (Specify only highest great	ucation de co <i>mpleted)</i>	16a. Decede (Give k	ent's Usual Occup ind of work done	oation during most of wor d)	king	16b. Kind of Busi	ness/Industry
121	within ene.	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>o not use retir</i> e emaker	d)		her own	n home
	should be filed within and Mental Hygiene. marked other than ametic event, the Manualic event, the Manualic event, the Manualic event, the Manualic event, the Manualic event has Manualic event.	17. Father's Name (First, Middle, Last)	0	Home	maker	18 Mother's Nan	ne /First Middle	, Maiden Sumeme	
Maryland	ntal H ed oth even	Thompson A. Bro	N.773			To. Motrior o train		ia Huyett	
7	d Men d Men marke matic	19a. Informant's Name/Relationship (7		19b Mailing	Address (Street	and Number or Ru		er, City or Town, Si	
Ma	id 2 sho ith end I 7 is me traume	Angela Talaber -			,				Virginia 22193
<u>ē</u>	Heal Heal Hern 2	20a. Method of Disposition		D. Place of Disposi			Date	20c. Location - C	
Baltimore,	Pages ment of ant: If it	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		lagerstow		cory	pril 23,2006		wn, Maryland
Ball	permit. Pages 1 end 2 Depertment of Health e important: If flem 27 is any injury or other tra DRGe.	21. Signature of Funeral Service Licent	iee O;		Name and Address East W	•		Funeral I gerstown,	Home Maryland 21740
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de	eath. Do not enter	r the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between
Jane .	Physician	Shook, of House land of List only t	and deade on deat mic.						Onset and Death
-4	/Medical	Immediate Cause (Final disease or condition	Acut	Maroca	-diel	Infanc	Cian		tukun
н	Examiner	resulting in death)	Due to	o (or as a consequ	ence of):	Infanci nelio Vica			
	Iner sit d		a Arteri.	· Scherol	لتر لا	ndio Van	ander	Direce	m
	erificate be executed ing physician end es the buriel-trensit	Sequentially list conditions,	Due to	o (or as a consequ	ence ol).				
68760,	requires that the death certificate be exected signed by the ettending physician end hould be deteched for use as the buriel-treated by Physician/Medical Exampted by Physician By Phy	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
87	physi the	that initiated events resulting in death) Last	Due to	o (or as a consequ	ence of):				į
×	ding		d						
Bo	es that the death cert igned by the ettendin be deteched for use by Physician/N								
P.O.	the d	Part II. Other significant conditions co	ntributing to death but not i	resulting in the und	derfying cause gr	ven in Part I.			ibute to the cause of death?
	that led by dete	Hopentinia	Hopeul	ipidem	~~		''	Tes 2L NO 3	Probably 4 Donkhown
Records,	The law requires th rate hes been signed page 2 should be d								24b. Were autopsy findings
Ö	200						peri	ormed?	available prior to completion of cause of death?
Re	he law ge 2 s						10	Yes 2 4M	1 Yes 2 No
ta	Han: The strift cate octor, pe Be Co	25. Was case referred to medical				26. Place of Dea		2007/2019	
of Vital	hysicia his cert il direct	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Oti			idence 6 Other	(Specify)
0	g Phy er thi neral	27. Manner of Death	28a. Date of Injury (Month, Dey Year	28b. Time of Injury	28c. inju Wo			how injury occurred	
Division	ath. r: Aft ne fur	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,		Yes 2□No			
Vis	or de er de recto by th	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stree	et, factory, office			(Street end Number wn, Stete)	or Rural Route Number,
	tal or Attanding P rs efter death. al Director: After ti led in by the funera Certification:								
	To the Hospital or Attanding Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		/sician: To the best of my liner: On the basis of exam and manner stated.						
_	within To the comp	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Month, Day, Year)
	5.* E	-tzva a	~D		DI	8019		APRIL :	22,2006
		30. Name and address of person who o	ompleted cause of deeth (I	Item 23a) (Type, P	rint)				
0	H-10	VASANT DAT			LLST	HAGE	2570W	~ ~0	21740
	State Registrar	31. Date filed (Month, Dey, Year)	32. Registrer's Sig	gnature And	de				

		1 - State Registrar	State of Ma	aryland / Depa	artment of F rtificate of		Mental Hy	/giene Reg. No	21111E	1433
Physicia		Decedent's Name (First, Middle, Last	st)				2. Date of D	eath Day	v Year	3. Time of Death
/Medic		John Joseph Ros	s Jr.				04		/2006	1652
Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of De	ath	4c.	County of Dea	ith
		Atlantic General			Berlin				rcester	
Funeral Director		5. Social Security Number 6. S 214-50-9591	V	(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	Hours Mi		irth <i>ay, Year)</i> 1947	9. Bi	thplace (State or Fore ountry) MD
D		Usual Residence of Decedent								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If lies 27 is marked other than "natural", or itams 23a or 28a-f ahow important: If the marked other than "natural", or itams 23a or 28a-f ahow any injury or other traumatic event. It a Mudical Exama ar must be motified at once.		10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Lim
Ba-f a	cto	MD Worcest	er	Ocean C	ity					MXYes 2□
or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What C	ountry?
236	a	11400 Coastal Hig			21842			US.		
Item I	nue	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	Hispanic Origin? an, Mexican, Pu	Specify Yes or Nerto Rican, etc.)	0-	 Race - Am Black, Whi 	
yes a rank the mean mean man are the state of death man are manyangle the state and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 ahow or other traumatic event. It a Medical Examinet man be motified at	Completed by Funeral Director	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 No	Specify:			Specify:Whi	te
tura	ed	15. Decedent's Ed		16a Dece	dent's Usual Occup	nation		16h Ki	ind of Business	Andustry
n ng	plet	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retired	during most of w	orking	100. K	ind of business	unioustry
iene.	Eo	Elementary/Secondary (0-12)	College (1-4or 5- 4		rvisor			Con	ntv Cov	vernment
Hyg other	BeC	17. Father's Name (First, Middle, Last)	•	1	2.2502	18. Mother's N	ame (First, Middle			ernmenc
ked ked	To B	John Joseph Ross	Sr.			Betty	Jane Gui	1den	er	
nd M		19a. Informant's Name/Relationship (19b. Maili	ng Address (Street					Zip Code)
27 ls		Sherry Ross (wife)	11400	Coastal	Hwv. #1	C Ocean	City	. MD 21	842
item othe	1	20a. Method of Disposition		20b. Place of Dispo			Date		cation - City or	
nt: If		XXBurial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specification)		Gardens o		' 1	27/2006	Ocea	n Pines	MD
Department Important: any injury once.		21. Signature of Funeral Service Licer		22	2. Name and Addre	ess of Facility R	urbage F	uner	al Home	, FID
Page Impo		Yannia line	Y Fall		08 Willia					
25 10		23 Part1. Enter the Jisease, or com shock, or hear failure. List only	plix tions that coursed							Approximate
		Immediate Cause (Final	A A							Onset and Deatl
hysician Medical		disease or condition resulting in death)		Y 6 CARD / a consequence of):	AL 1	NIMAC	TION	·		FEW MINIS
xaminer			<i>U</i> .		SIVE 1	11500-	21000	C. II.		m
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ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events	C							
en and rial-trar		resulting in death) Last	Due to (or as a	a consequence of):						
ysicien ne burial	cai		d							
attending physic	led							- 010		
endir	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy				23d. Date of de	livery
e att	icle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Other (specify)	у			Month	Day Year
detached	hys	9 ☐ Unknown	9□ Unknown							
igned to	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	ise contribute t	o the cause of death
been sig	ed	OBESITY.					1 🗆	Yes 2	□No 3 P	robably 4 🗆 Unkn
s been 2 shoul	Completed						24a. Was		24b. Were a	utopsy findings availa
page 2	mo							ormed?	death?	completion of cause
certificate rector, pag	0)	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only	2 No	1 L Yes	5 2□ No
s cert	To B	examiner? 1™X Yes 2 □ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	nt 3 DOA Oth		Home 5 Res		e Dother /e-	
ar this Brail di		27. Manner of Death	28a. Date of Injur	y 28b. Time o	. 30 504	- Li Huraning	28d. Describe			icity)
th. : After s funer	tlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		rk? Yes 2 □ No				
octor	fice	3 ☐ Suicide 6 ☐ Could not be	286. Place of Inju	iry : At home, larm, str	eet, factory, office		28f. Location	(Street an	d Number or R	ural Route Number.
after Dire d in b	Certification;	4 Homicide determined	building, etc	(Specify)	,		City or To	wn, State)	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th		29a. Certifier 1 Certifying Ph	ysician: To the best o	of my knowledge, deat	h occurred at the tir	me, date and pla	e, and due to the	cause(s)	and manner a	s stated.
n 24 he Fu	Medical	one)	niner: On the basis of and manner sta	examination and/or in ted.	vestigation, in my o	ppinion, death oc	curred at the time.	, date and	I place, and du	e to the cause(s)
To t	Σ	29b. Signature and title of certifier			29c. Licens			29d. Dat	e signed (Mon	th, Day, Year)
		Sorothis C	Hohwatt	ml	2	06241		4	4-23-6	06
	1	30. Name and address of person who		eath (Item 23a) (Type,	Print)		THO 17 1			
5						v Hill.	MD 21863			
Star		Dr. Dorothy C. Ho 31. Date liled (Month, Day, Year) APR 2 4 2	32. agistra	03 Snow St		J.	ow Hill, 1	ow Hill, MD 21863	ow Hill, MD 21863	ow Hill, MD 21863

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Donald Roseberry, Jr. UVt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Ill 900, Cantu Flams If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**XX**M 2□ F 302-24-2763 Yrs. Director 74 1932 Ohio Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes XX No Completed by Funeral Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 202 Somerset Bay Drive, #101 Items 23a 21061 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after 1XXYes 2 □ No If Yes, Give Year or Dates: 1950-54 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) V.P. Sales Waste Management other treumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Donald Roseberry, Sr. Elsie Garbrandt Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 202 Somerset Bay Drive, #101, Glen Burnie, MD 21061 Betty Jane Roseberry (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State io i 1 Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 4-24-2006 Crownsville, MD 21. Signature of Fyneral 8 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jak 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes Yes 2 No 2 No or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 The patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division f ☐ Vatural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

istrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Reed April 2006 16 2:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2441 Blue Spring Court, #101 0denton Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 □ XF Yrs. 213-20-5795 80 Director Oct. 25,1925 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 ie marked other then "neturel", or Items 23a or 28a-f ehow other treumatic event, the Medical Examinar mast be notified at 1 Yes 2 No Directo MD Anne Arundel 0denton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2441 Blue Spring Court, #101 21113 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black. White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White þ Specify. 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Bookkeeper Heating & Air Condition permit. Peges 1 and 2 should be flit Department of Health and Mental Hy Importent; if Item 27 is marked oth eny linjury or other treumatic event Quee. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William McDorman Dorothea Lantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 569 Brightwood Road, Millersville, MD 21108 Lynda J. Carnochan (Niece) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 4-19-2006 Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service Licenses Dalre 851 Annapolis Road, Gambrills, MD 21054 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disorder **Physician** hronic disease or condition resulting in death) /Medical Due to (or as a sonsequence of): Examiner 20 4 weeks MUXO COSTO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of Examiner ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 autopsy 1 Yes To the Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined within 24 hours after dea To the Funersi Directo completaly filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinto 112 Annapolis MD 21401 ChambersMD 133 Detense

Registrar

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:22 A 2006 15 April Josephine Rizzo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Thurmont 14 Hammaker Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🛛 F Yrs 8, Ohio 88 Director 579-03-5278 Usual Residence of Decedent within 72 hours after deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Itam 27 is marked other than "natural", or Itams 23s or 28s I show other traumatic avant, the Medical Examiner must be notified at 1 X Yes 2 No Director Thurmont Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21788 United States 14 Hammaker Street Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify Specify þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Publishing 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Imbordino Simone Barravechia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Thurmont, Maryland 21788 14 Hammaker Street Diane Lewis / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 18, 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2006 Thurmont, Maryland Blue Ridge Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Thurmont, Maryland 21788 104 E. Main Street 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical auence of): Examiner Sequentially list conditions, lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death bet not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 € No this certificate has been si al director, page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital : After this certification at tuneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Medical Certification; To Be Other 4 Nursing Home 5 desidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Matural 5 Pending investigation s effer de... ej Diractor: Afr 1 Tes 2 No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 Homicide within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies leted cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

1

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

	Plea	se Type or						-	-	jible.	
For State		State	of Maryland	-	artment <i>tificate</i>			_	00.000	7 (11.001.
Registrar Decedent's Name	e (First, Middle	e, Last)		001	uncate	OI DO	alli	2. Date of De	Reg. No.		3. Time of Death
MIRI	AM B.	SAULSBURY						APRIL	1 9	Year 2006	8:30PM M
4a. Facility Name (II			ımber)		4b. City, T	own, or Loc	ation of Death			ty of Death	3,30111
		CE HOUSE				EAST				TALI	
5. Social Security N 215–82–3	707	6. Sex 1 ☐ M 2 🔏 F	7. Age (In yrs. In 91	ast birthday) Yrs.	If Under 1 Months		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da OCT 5,	y, Year) 1914	9. Birthp Coun MARY	lace (State or Foreign try) LAND
Usual Residence of 10a. State	10b. County		10c. City	, Town or La	cation					1	0d. Inside City Limits
MD	TAI	LBOT		EAS	TON						1 Yes 2 □ No
10e. Street and Nur	mber	***			10f. Zip (Code			10g. Citizen o	f What Cour	itry?
108 NO	RTH HIC	GGINS ST.				21	601			USA	
11. Marital Status 1 ☐ Never Marri 3 Widowed	_	ried 1 ☐ Yes	2 🖰 No ive	- 1	Was Decede f Yes, speci 1 ☐ Yes 2	V	nic Origin? (Sp lexican, Puerto pecify:	pecify Yes or No Rican, etc.)	Spec	ace - Americ ack, White, hity: WHI	etc.
(Spec	cify only highe:	t's Education st grade completed) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done durin	n ng most of work	king	16b. Kind of	Business/Ind	dustry
12		2	(1-401 3+)	HON	IEMAKE	R			0	WN HOM	E
17. Father's Name		Last) ENGMAN, S	R.			18.		e (First, Middle, PLUMMER		ame)	
19a. Informant's Na		thip (Type, Print)	FR		-			ral Route Numbe			Code)
20a. Method of Disp	position	3 □Removal from	20b. Pl	lace of Dispo emetery, crer	sition (Name	e of ner place)		Date /2006	20c. Location		
shock, or hea Immediate Cause disease or condition resulting in death)	the disease, or ant failure. List (Final	r complications that only one cause on Due to	caused the death	n. Do not ent	or the mode	HEL HARRI of dying, s	FENBEIN SON ST		MD 21	ERAL H	Approximate Interval Between Onset and Death,
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nmediate erlying injury s	S c	o (or as a consequ								
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	! months? □ No	1 Live	utcome of pregna birth 2 Fetal gnant at time of de nown	death 3	Ectopic pre Other (spe					Date of delive	ory Day Year
Part II. Other signif	ficant condition	ons contributing to	death but not resu	ulting in the u	nderlying ca	use given ir	Part I.	23e. Did t		ntribute to th	e cause of death? ably 4 □Unknown
								24a. Was autor perfo		D. Were auto prior to condeath?	psy findings available appletion of cause of 212 No
25. Was case reference examiner?	rred to medica	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DO/	Other		th <i>(Check only c</i> ome 5 ☐ Resid		ther (Specif	HOSPICE
27. Manner of Deat Natural 2	th 5 Pendir investi 6 Could determ	ng (Mo igation not be 28e. Plac	e of Injury nth, Day Year) se of Injury - At ho ding, etc. (Specify	28b. Time o Injury	М		2 🗆 No	28f. Location (City or Tou	now injury occ	urred	l Route Number,
29a. Certifier (Check only one)	Certifyir 2	ng Physician: To the Examiner: On the and ma	ne best of my know basis of examinat nner stated.	wledge, deat tion and/or in	h occurred a vestigation,	it the time, o	date and place, on, death occur	, and due to the rred at the time,	cause(s) and date and place	manner as si e, and due to	ated. the cause(s)
29b. Signature and	title of certifie	w Fise	la M.	0	29c.	License nu	725	on Mi	29d. Date sign	20,	Dey, Year) 2006
30. Name and addr	ress of person	who completed car	use of death (Item	23a) (Type,	Print)	on t	East	on Mi	0 21	601	

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registra

APR 2 1 2006

an	1 - For Stete Registrar WEND#15perFH4 1. Decedent's Name (First, Middle, Las	t)	Certificate of		2. Date of Death Month	Day Year	3. Time ol Death
al	ELAINE SEHRT-GREEN			A		2006	11:30 A
er	4a. Facility Name (If not institution, give	street and number)		r Location of Death		4c. County of Deati	
	SUBURBAN HOSPITAL	7 4-2 (12) 22 (22)		HESDA	Date of Birth	MONTGO	
	5. Social Security Number 6. Sec. 264–68–4860	7. Age (In yrs. last	Yrs. Months Days	Hours Min	B. Date of Birth (Month, Day, Y UNE 4,]	(ear) 1946 FLOR	hplace (State or Fore untry) CIDA
	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Lim
ctor	MARYLAND MONTG	OMERY	P	OTOMAC			1 □ Yes 2 1 1
	10e. Street and Number 12105 REACH WAY		10f. Zip Code	20854	10g	D. Citizen of What Co	•
Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Spec	fy Yes or No-	14. Race - Ame Black, White	
by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No	Specify:	out, 5(5.)		HITE
etec	15. Decedent's Edi (Specify only highest grad	ucation 16 de completed)	Sa. Decedent's Usual Occup (Give kind of work done)	during most of working	7	b. Kind of Business/	Industry
Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	life. DO NOT use retired ATTORN			ISPUTE ESOLUTION	
Be Co	17. Father's Name (First, Middle, Last)		ATTORK	18. Mother's Name (
ToB	VERNON R. SEHRT			INABELL	E MORREI	LL	
	19a. Informant's Name/Relationship (7 GEORGE GREEN/HUSBA	ype, Print) 1 ND	9b. Mailing Address (Street & 12105 REACH W	and Number or Rural AY, POTOMA	Route Number, C .C,MARYI	City or Town, State, Z LAND 2085	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	0.000	of Disposition (Name of tery, crematory or other place	Da Da	te 20	c. Location - City or	Town, State
	4 □Donation 5 □ Other (Specify	GARDI	EN OF REMEMBR	ANCE 04/21	/2006 CI	LARKSBURG,	MARYLAND
	21. Signature of Funeral Service Licens	666	EDWARD SAG	ss of Facility EL FUNERAL	DIRECT	ION, INC.	
	23a, Part Finter the disease.	lications that caused the death. D	1091 KUCKV	ILLE PIKE,	ROCKVII	LLE, MARYL	
	shock, or heart lailure. List only o	ne cause on each line.			respiratory arrest	ι,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a CLOSTRIDIUM D		TIS			21 MONTH
		Due to (or as a consequence NEUTROPENIA SI		ዘ <i>ም</i> ለ ምህም አ ላን	y ·		1 WEEK
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence		HEROTHERM.	_		I WILL
Examiner	that initiated events	c METASTATIC BRI	EAST CANCER				3 MONTHS
	resulting in death) Last	Due to (or as a consequence	ce of):				
dicai		d					
/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				22d Date of deli	
Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of deli	Day Year
Ph	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ed by					1 ☐ Yes	2 X No 3 □ Pro	obably 4 Unknow
Completed					24a. Was an		topsy findings availal
mo:					autopsy performe	d? death?	completion of cause of
Be	25. Was case referred to medical examiner?			26. Place of Death			
မ	1 ☐ Yes 2 📉 No		Outpatient 3 DOA Oth	4 Nursing Home		e 6 □Other (Spec	cify)
ion	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	D. Time of Injury Work	/ at k? Yes 2 □ No	d. Describe how	injury occurred	
	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,			f. Location (Stree	et and Number or Ru	ral Route Number.
fica	4 Homicide	building, etc. (Specify)			City or Town, S		
Sertifica		sician: To the best of my knowled iner: On the basis of examination	and/or investigation, in my of	ne date and place an pinion, death occurred	d due to the caus I at the time, date	eo(e) and manner as and place, and due	stated. to the cause(s)
dical Certification;	29a Certifier 1 X Certifying Phy (Check only 2 Medical Exam one)	and manner stated.					
Medical Certifica	(Check only 2 Medical Exam	and manner stated.	29c. License	number	29d	. Date signed (Month	Day, Year)
	one)	A Hulu	29c. Licenson D372		I	Date signed (Month APRIL 18,	
	one)	and manner stated. Difference of death (Item 23)	D372	36		APRIL 18,	2006

		1 - For State Registrar		State of	Maryla		artment d <i>rtificate</i> :			ind M	ental Hyg	giene leg! No			11,336
		Decedent's Name (First, M.	iddle, Last)								2. Date of Dea	ith			3. Time of Death
Physici /Medi		Reatha Jo	ann	Hane	s	Smith					Month April	Da 1	<u> </u>	_{Year} 06	8:05 A M
Examir		4a. Facility Name (If not instit	ition, give s	street and num	ber)		4b. City, Tov	wn, or L	ocation of	f Death		40	. County o	f Death	
	Ш	971 Shady De					0akla						Garr		
Funeral		5. Social Security Number	6. Sex	M 2 🖫 F		s. last birthday) Yrs.	If Under 1 Y Months D	ays	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year,			place (State or Foreign htry)
Director		578-38-7612 Usual Residence of Deceden		21	75						Jan. 1	, .	1931	Was	shington Do
yland		10a. State 10b. Con			10c. C	City, Town or Lo	ocation							1	10d. Inside City Limits
e-fel	Ş	MD Ga	rrett			0ak1and	l								1 ☐ Yes 2 X No
or 28	Director	10e. Street and Number					10f. Zip Co	de		- "		10g. Ci	tizen of Wi	nat Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Benyt injury or other traumatic event, tra Medical Examination at the notified at once.	la l	971 Shady De	11 Ro	ad			21	550				Uı	nited	Sta	ites
filed within 72 hours after death with the Maryland Hygiona. Inter then "naturel", or items 23e or 28e-f ehow ent, it e Medical Exambat must be notified at	Funeral	11. Marital Status		12. Was Deced Armed Ford	es?		Was Decedent If Yes, specify	of Hist Cuban	panic Orig , Mexican,	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)			- Americ , White,	ean Indian, etc.
rs aft	by F	1 ☐ Never Married 2 ☐ ☐ Never Married 2 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		1 Pes 2 If Yes, Give Year or Dat			1 □ Yes 2 X	No	Specify:				Specify:		
ture			dent's Educ			16a, Dece	dent's Usual O	ccupati	ion		1	16b K	(ind of Bus	Whi	
nin 7	Completed	(Specify only hi	phest grade	completed)	45-1	(Give	kind of work d DO NOT use ri	one du		of workir	ng	100.1	and or bus	1110337111	dustry
d with	E	12	2)	College (1-4	40r 5+)	Regi	stered	Nu	rse			Nui	csing		
z snould be tiled within and Mental Hygiene. ie marked other then aumatic event, the Market	Bec	17. Father's Name (First, Mid	dle, Last)							r's Name	(First, Middle,)	
nd Mental marked c	10	Paul Hanes							Rea	atha	Dav	İs			
and ie ma		19a. Informant's Name/Relat	onship (Ty)	oe, Print)		19b. Mailir	ng Address (St	reet an	d Number	r or Rura	l Route Numbe	r, City	or Town, S	tate, Zip	Code)
Health tem 27 other tr		Joyes Jolles	, Dau	ghter					1 Roa		akland,				
or of H		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremati	on 3 □R	emoval from Si		Place of Dispo cemetery, crer	sition (Name o natory or other	of r place)		D	ate	20c. L	ocation - C	ity or To	own, State
tant:		4 □Donation 5 □ Othe	(Specity)			umber1a	ınd Crei	mat	ory 4	/21/	06	Cı	ımber	1and	, MD
Department of High Indiana of Partment of High Indiana of Other Partment of High Indiana of Other Partment of Other Part		21. Signature of Feneral Sen	ice License	90	4.	22	2. Name and A	ddress	of Facility	['] Bur	dock-Di	ırst	Fun	era1	Home
102 0 a	_	23a. Part1 Enter the disease	(I, D)	Ludo	CR								iklane	d, M	D 21550 Approximate
hysician and property the private in	dical Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (o		equence of):	छा।८०	Di	20N	AR	4045	cı	Da	Y	Interval Between Onset and Death
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2:		th 2 ☐ Fet nt at time of	tal death 3	Ectopic pregn Other (specify						23d. Date Monti		Pry Day Year
within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant con	ditions con	tributing to dea	th but not re	sulting in the u	nderlying cause	e given	in Part I.		23e. Did to	bacco	use contrib	ute to th	ne cause of death?
should t											1 □ Y	es 2	□ No 3	Prob	ably 4 Unknown
has be	Completed										24a. Was a		24b. We	ere auto	psy findings available
page	E O										autop: perfor		de	ath?	npletion of cause of
nis certificete director, pag	Bec	25. Was case referred to med examiner?	lical					2	26. Place	of Death	(Check only or	e)			2010
w =	70 5	1 Yes 2 No	Н	ospital: 1 🗌 Inp	patient 2] ER/Outpatien	t 3 DOA	Other	4 Nur	sing Hor	ne 5 Resid	ence	6 Other	(Specify	1)
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral c	Certification:	3 ☐ Suicide 6 ☐ Co	stigation uld not be		Day Year)	28b. Time of Injury	М		it es 2□N	io	8d. Describe h				
ours after eral Dire filled in by		4 Homicide del	ermined	building), etc. <i>(Spec</i>						City or Tow	n, State	e)		l Route Number,
n 24 hc ne Fun iletely i	edical	29a. Certifier Certifier (Check only one) Medi	cal Examin	er: On the bas and manne	is of examin	owledge, death ation and/or inv	occurred at the vestigation, in r	ne time, my opin	, date and nion, death	place, a h occurre	nd due to the cod at the time, d	ause(s ate and) and manr d place, an	ner as st d due to	ated. the cause(s)
withit To the comp	Me	29b. Signature and title of cer	rifier			^	29c. Lic	cense r	number		2	9d. Da	te signed (Month	Day, Year)
		1 Kaul P	MM	SMILL	er V	Ø	н	2615	54			4	12	11	06
		30. Name and address of per-	on who cor	mpleted cause	of death (Ite	m 23a) (Type,						/_	1	- /	J B
		Dr. Daniel P	. Mil	ler 6	9 Wo1:	f Acres	Drive.	. 0a	ıklan	d, M	D 21550				
Sta		31. Date filed (Month, Day, Yo	ar)		trar's Sign										

ORIGINAL

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			For State	State of Maryland	Department of Health and	Mental Hygie	ne	
			= State Registrar		Certificate of Death	Reg.	No. 1006 1433	1
			1. Decedent's Name (First, Middle, Last			2. Date of Death	3. Time of Death	
	Physic (Mode		Julia G	eraldine	Smith	APr. 1	22 2006 0535 M	М
	/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	
	LXUITIII			4 / 2	1 1 0 1 1			
			5. Social Security Number 6. Se	eneral Hospi			Dorchester Osman Familia	_
	Funeral Director			M 20 F	Yrs. Months Days Hours Mir	. (Month, Day, Ye		
	Director		Usual Residence of Decedent	0 3		Dec. 25,	1920 Maryland	
	land		10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limit	s
5	Maryland -f show lied at	ö	MD Do al	0			1 1 1 Yes 2 □ N	
4	the h	ect	10e. Street and Number	lester C	ambridge			
\mathcal{H}	with o	ä			Tor. Zip Code	10g.	Citizen of What Country?	
۲	be filed within 72 hours after death with the Marylan Ital Hygiene. ad other than "natural", or flems 23a or 28a-f show event, the Medical Examinat must be notified at	Funeral Director	517 Pine	Street	21613		USA	
0	r de	l le	11. Marital Status	 Was Decedent Ever in U.S. Armed Forces? 	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
9	after or Ite		1 Never Married 2 Married	1 ☐ Yes 2 12 Ño If Yes, Give	1 ☐ Yes 2 12 No Specify:	, , , , , ,	Specify: 0:	
Ö	ours raf',	1 by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			BIACK	
5-0036	72 h natu fical	Completed	15. Decedent's Edu (Specify only highest grad	cation 10	6a. Decedent's Usual Occupation	16b	. Kind of Business/Industry	
2121	thin	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	Sixing		
7	d will be a series	Ö		I	eacher Assist	ant Bo	pard of Education	,
Þ	filed I Hygi other	Be (17. Father's Name (First, Middle, Last)			me (First, Middle, Maid		
a	ld be ental ked c ic ev	To B	Charles	E. Cornis	Mana	aretta	11'110-	
\leq	2 should be and Mental is marked of aumatic eve	-	19a. Informant's Name/Relationship (Ty		9b. Mailing Address (Street and Number & F		ity or Town State Zin Code)	
Maryland			San An	1.	-170' CI +/	1	y or , own, orace, 2p code)	2
	1 and Health tem 27	1 3	20a. Method of Disposition	derson	of Disposition (Name of	ambride Date 20	e, Maryland 2141.)
Ö	Pages nent of H int: if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	etery, crematory or other place)	755	Location - City or Town, State	
ᆵ	artmen ortant: injury		`4 ☐ Donation 5 ☐ Other (Specify)	Bet	hel Cemetery 4/	27/06 C	inbridge Marylan	d
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other trong.		21. Signature of Funeral Service Licens	90	22. Name and Address of Facility Henry Funera	1 Home. P.	A. 37 216	
m	Den Impa		Janelle (2. Denry	510 washing to	VSt. COM	bridge, Maryland	13
			23a. Part Enter the disease, or compl	cations that caused the seth. D	o not enter the mode of dying, such as cardia	ic or rapiratory arrest,	Approximate	-
	DI		Immediate Cause (Final	ne cause on ach line.	M 1 T	- (Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Howe	11 WOCARDIAL LI	ntarctic	n 2days	4
	Examiner			Due to the as a consequence	ce of):			
		L.	Sequentially list conditions,). =				
	p ii	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	ce of):			
	acute and trans	Examiner	that initiated events resulting in death) Last					
Ó	e be exer	ш Ж	resulting in death) Last	Due to (or as a consequence	e of):			
190		ca		l				
.89	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi						
Вох	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery	
m	atte atte I for	cla	in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death			Month Day Year	
P.O.	the d the chec	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	- L 4 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1			
	that I	P	Part II. Other significant conditions con	stributing to death but not resulting	in the underlying cause given in Part I	23e Did tobaco	co use contribute to the cause of death?	
Records,	res t signe be	Completed by	Augist Fibel	12+ 00 11.	2 = (2 -)		10	
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သို	as be	pie	Hypertpusion,	IUPE II. DI	Ahetes	24a. Was an	24b. Were autopsy findings available	е
ď	The te his age	E O	,			autopsy performed	prior to completion of cause of death?	
Vital	iffica or. p		25. Was case referred to medical		OC Place of De	1 ☐ Yes 2 🔀	No 1 □ Yes 2 0 No	
>	Physician: this certificatal director,	o Be	examiner?	ospital:	04		-	
of	Phy this ral d	2 :	27. Manner of Death		outpatient 3 DOA 4 Nursing i	Home 5 Residence		_
L	ling After fune	lo	1 Pending 5 ☐ Pending	(Month, Day Year)	Injury Work?	28d. Describe how in	ijury occurred	
Sic	tend leath tor: the	cat	Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	ter clirec	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)	
	ital or rail Dedi	ပိ						
	hour une une	cai	29a. Certifier Sertifying Phys	sicien: To the best of my knowled	lge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	e, and due to the cause	s(s) and manner as stated.	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	ane)	and manner stated.	and or investigation, in my opinion, death occi	urred at the time, date a	and place, and due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Mghth, Day, Year)	
			pro all b	~ 1/U,	# 44615	1	1125/01	
			30. Name and address of person who co	mpleted cause of death (Item 23a	(Type Print)	/	1000	
			Loils Al. Narry D.	0. 100 R	amble St	On loc	() co Man 711.2	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	-11-10-10-1	amk!	100 x 1613	
	Registr		APR 2 6 2	006 Page	& Boards		\cup	

	1	For Amend Item State Registrar			Cer	tificate of	Death		Reg. No.		14338
hysician		Decedent's Name (First, Middle, L.	•					2. Date of I		, Xear	3. Time of Death
/Medical		Sandra Sheppare						Febru		4, 2ŎÖ6	2:22 A M
aminer	1	ta. Facility Name (If not institution, gi		1)		4b. City, Town, o Baltimor	r Location of Death	n	- 1	County of Death	
		1333 Church Strom Strom Strom Strom Scial Security Number 6.		Age (In yrs. last)	hirthday)	If Under 1 Year	If Under 24 Hrs.	9 Date of F			
ral tor	1		1 M 2 XF	48	Yrs.	Months Days	Hours Min.	8. Date of E (Month) 11-27	57 Year)	9. Birthp Coun	place (State or Foreign etry)
		10a. State 10b. County		10c. City, To	own or Lo	cation				1	0d. Inside City Limits
ctor		Md.		Balt	imor	e					1. ZAYes 2. □ No
Sire		10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cour	ntry?
page. To Be Completed by Funeral Director		1333 Church Str	eet			21226			U	SA	
Completed by Funeral Director		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Vivorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? ₹TMO	If	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or f o Rican, etc.)	10-	14. Race - Americ Black, White, Specify: Whi	etc.
eted	Ī	15. Decedent's E (Specify only highest gr	ducation	16	a. Deced	ent's Usual Occup	ation during most of wor	kina	16b. Ki	ind of Business/Ind	dustry
jd H	Ġ	Elementary/Secondary (0-12)	College (1-4o		life. E	O NOT use retired	1)	Kii i g		. 1. 1	
		4 7 Frank and Alama (Frank Adiable 4 and	2		Medi	cal Assi				Medical	
Be		17. Father's Name (First, Middle, Las Charles Sheppar	-				18. Mother's Nan	Garber		Sumame)	
၉		19a. Informant's Name/Relationship		10	Ob Mailin	a Address (Street	and Number or Ru			Town Chata Zin	0-41
	<u>.</u>	Patrick Robinso			127 Cr	ocus Ave,	Wildwood C	rest, NJ	08260)	
	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ceme	tery, crem	ition (Name of atory or other place 1e Cemete	ery 2/18,	Date /2006	211	eyville,	
once.		21. Signature of Funeral Service Lice				Name and Address					
a		Timothy S	• Harwan	per D	VR H	orrakan Fu	meral Ho	100, 100 100	shuro	n Street NJ 083	27
for use es the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence							
Med		IF FEMALE:	20. #		-						
Physician/M		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy Other <i>(specify)</i>			2	23d. Date of delive Month	ry Day Year
þ	F	Part II. Other significant conditions	contributing to death	but not resulting	in the un	derlying cause give	en in Part I.		tobacco u	se contribute to th ☑No ③∰Proba	e cause of death? ably 4 DUnknown
Completed	-				-			24a. Wa aut per 1 Yes	opsy formed?	24b. Were autor prior to con death? 1 \(\sum \text{Yes}\)	osy findings available apletion of cause of
Be (1	25. Was case referred to medical examiner?				- V-	26. Place of Dea	th Check only	one)		
은	L	t∕∑Yes 2 No		ient 2 ER/C			4 Nursing n			Other (Specify)
ertification:	1	27. Manner of Death 1X□Natural 5 □ Pending 2 □ Accident investigation		ay Year) 28b	Time of Injury	28c. Injury Work M 1 🗆 `	vat ⟨? Yes 2 □No	28d. Describe	how injury	y occurred	
Certification:		3 Suicide 6 Could not be 4 Homicide determined	286. Place of Ir	njury - At home, etc. (Specify)	farm, stre	et, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rural	Route Number,
Medical Co		29a. Certifier (Check only one) 1 Certifying Pl 2 Medicaf. Example 1	nysician: To the bes miner: On the basis and manner s	of examination a	ge, death and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the	e cause(s) , date and	and manner as sta place, and due to	ated. the cause(s)
ž	1	29b. Signature and title of certifier	1			29c. License	number		29d. Date	e signed (Month, L	Day, Year)
		· Shul				0.C.	M.E.		May 3	3, 2006	
		David Fowler,	M.D.	111 Per			ltimore,	Maryla	nd 2	1201	
State egistrar	3	31. Date filed (Month, Day, Year) MAY 0 5 2006		trar's Signature	A						
Rev 1/2001	ı	MAY 0 5 2006	Messer!	the first	119			-			T 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. C.

			1 - State Registrar			viai ylai				Death	_	Reg.	4001)	1433
	Physici	an	1. Decedent's Name								2. Date of Month		Day Ye	ar	3. Time of Death
	/Medio		Erie H 4a. Facility Name (If I		nompson	er)		4h City	Town	or Location of De	April	19,	2006 4c. County of E		9:37 A
	Examin	ier		ın Hospit		/			hesd		atti		-		
	Funeral		5. Social Security Nu	mber 6. S	iex 7.	Age (In yrs.	last birthday,	If Unde	or 1 Year	If Under 24 H		f Birth	Montgo 9.		ce (State or Forei
	Director		277-05-631 Usual Residence of D	.3	M M 2□ F	87	Yrs.	Months	Days	Hours Mi	Sept.	16, Day, Ye	1918 M	ichi	gan_
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do chter than "natural", or itema 23a or 28a-f ahow avant, the Medical Examinar must be motified at	_		10b. County		10c. Cit	y, Town or L	ocation						10d	. Inside City Limi
	8a-f	Director	_	Montgome	ery	Pot	omac								1- Yes 2□N
	vith th	Dire	10e. Street and Numi					10f. Zi	p Code			10g.	Citizen of Wha	t Country	n
	eath y	Funeral	8912 Barro	wgate Co	urt 12. Was Decede	nt Ever in III	C 12	208		finnania Oninina	(C4-V		S.A.		to do
10	ter d	Fun	11. Marital Status 1 □ Never Marrie	d 2∏ Married	Armed Force 1 Yes 2			If Yes, spi	ecify Cuba	lispanic Origin? an, Mexican, Pu	erto Rican, etc.	.)	14. Race - A Black, V	Vhite, etc	
38	urs a	þ	3 ☑ Widowed 4	_	If Yes, Give Year or Date	s: 194	46	1 ☐ Yes	2 ₩ No	Specify:			Specify: W	hite	
5-0	72 ho	Completed	(Snecifi	15. Decedent's Ed y only highest gra	ducation		16a. Dece	dent's Usu	al Occup	pation	orking.	16b	. Kind of Busine	ess/Indus	stry
2	Men.	nple	Elementary/Second		College (1-4	or 5+)				during most of w	orking .				
2	led w lygier her ti	S	17 Fathada Nama /F	Time Middle Load	4		Bus	iness	Exe	cutive	/=:		.E.B. G	roce	ry Co.
and	ntal F ed of	Be	17. Father's Name (F							18. Mother's N		ddle, Maid	den Sumame)		
Ë	should be f and Mental I a marked of umatic ava	ဥ	Erie Sto		IDSON		19h Maili	ing Address	s (Street	Lulu l		umbor Ci	ibrar Town Sta	to Zio Co	nda)
Za Za	end 2 sealth an n 27 ia.		Michael E		•	on				te Ct. 1					
စ်	Head The Head		20a. Method of Dispo	osition		20b. F	Place of Disposemetery, cre	osition (Na	me of		Date	200	Ly Land :. Location - City		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment if the Z7 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic avant, its Macical Examinar must be notified at once.			Cremation 3 ☐ 5 ☐ Other (Specif]Removal from Sta v)	119	ssion l	•	,	/ Api	cil 24 , 2006		n Anton	io '	Texac
alti	permit. Depertm Importal any inju		21. Signature of Fund							ss of Facility J					
ä	Depermine Poly in Poly		Selle	11/3	padua					nsin Ave					
			23a. Part1. Enter the shock, or heart	e disease, or com failure. List only	plications that caus	sed the deat	h. Do not en	ter the mo	de of dyin	ig, such as cardi	ac or respirato	ry arrest,		A	pproximate terval Between
F	Physician		Immediate Cause (F disease or condition	inal	, Colon									0	nset and Death
	/Medical Examiner		resulting in death)		u	as a conseq	uence of):								ou _j o
	LAdimine	<u>_</u>	Sequentially list cond	ditions,	b. Due to /or										
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.89	tificat ig phy as the	ledical											1		
Вох	attending for use	N/us	IF FEMALE: 23b. Was decedent p		23c. If yes, outcor 1□Live birth	ne of pregna	incy	⊒Ectopic p	recessor	,			23d. Date of	delivery	
	Physician: The law requires that the death cer this certificete has been signed by the attendir ral director, page 2 should be detached for use	Physician/N	in the past 12 m 1 Tyes 2 T		4☐Pregnant	t at time of d		Other (s				_	Month	Da	y Year
P.O.	at the ded by the etached	Phy	9 Unknown									5-2			
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Vital Record	w require been si should b	Completed	Respirat	Oly Ilisu	rrrcrenc	У					-				y 4 ₁ ⊋Unknow
360	e law has t je 2 s	mpt									a	Vas an utopsy erformed	24b. Were prior death	to compl	findings availab letion of cause of
<u>a</u>	ician: The I certificate ha rector, page					_					1 🗆 Y	s 2√2		es 2	2 No
્≓∶	iysiciar iis certii directo	o Be	25. Was case referre examiner?		Hospital:				Oth	26. Place of D		0.0			
ō	Phys ar this aral di	⊢	1 ☐ Yes 2 N N 27. Manner of Death		28a. Date of le	njury	ER/Outpatier 28b. Time o		28c. Injun Worl	4 🗀 IAUI SILIY			e 6 □Other (S	Specify)	
<u>o</u>	anding leath. or: After the funer	atlor	1X Natural 2 ☐ Accident	5 Pending investigation		Day Year)	Injury	м		k? Yes 2∐No					
Division of	E 0 % C	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	Injury - At he	ome, farm, st	reet, factor	y, office		28f. Locatio	on (Street	and Number of	Rural R	oute Number,
Ö	rs afte	Cert			Danang,	etc. (Specify	Y)				City di	Town, St	are)		
Division	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)	Certifying Ph	ysician: To the be niner: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred ivestigation	at the tin	ne, date and plac pinion, death oc	ce, and due to curred at the ti	the cause ne, date	e(s) and manne and place, and	r as state due to the	ed. e cause(s)
	To the within 2 To the complex	Me	29b. Signature and til	tle of certifier .	0 5			29	c. License	e number	-	29d.	Date signed (M	onth, Day	y, Year)
	10) de	me	7	XX	7	'ת	37891	L			ril 19,		
**	LU		30. Name and address	ss of person who	completed cause of	of death (Item	n 23a) (Type,	1				A	/L L L J ,	200	,,,
SE I			A Rajvansl					•	‡409	Rockvi	lle. MT	208	352		
	Sta		21 Date filed (Month	Day Voorl		htrada Ciona	turn	-							
	Registr	ar		HEK 2 T	ZUUID 🔐	agille.	15 1	A 200	Name of the last						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Apri1 10:30 p^M Alice Thompson 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Spa Creek Annapolis Anne Arundel Annapolls
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.
Sept. 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X 52 Director 1953 Washington, DC 212-64-7072 Usual Residence of Decedent 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f ehove the Medical Exeminer must be notified at 1 ☐ Yes 🕺 No Director Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Mayfield Road 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 other than Elementary/Secondary (0-12) College (1-4or 5+) Production Manager 10 Canada Dry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be fill ment of Heelth and Mental Heent: If Item 27 is marked ott Isaac William Weadon Margarete Sally Kroon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Weadon (Brother) 1514 Mayfield Road, Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Importent: If any Injury or QDCE. 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 4-24-2006 Brentwood, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service Licensee Ĵ. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ovarian Concer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) ettending physicien and for use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö certificete has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death | Check only one Hospital: Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? Certification; 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Division s after dee. 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a

To the Funeral C

completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 18 WITH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 20 LUUD Registrar

		1 - For State Registrar	State of Maryla		artment of H		nd M		giene	2005	14341
Physi	ician dical	1. Decedent's Name (First, Middle, L	ssallo					2. Date of Dea	ith	200 6 ar	3. Time of Death 6:32A. M
Exam		4a. Facility Name (II not institution, g Casey House	ive street and number)		4b. City, Town, o	Location of ille	Death			ontgome	ery
Funera Directo		577-40-2069	Sex 7. Age (In yrs	s. <i>last birthday)</i> 76 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth	, 19 29		lace (State or Foreign lington, D.C.
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	_	City, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 📉No
h with the	ai Direc	10e. Street and Number 4514 Ammendale F	load		10f. Zip Code	20705			10g. Citizen of What Country? United States		
DEIKIMOFE, IMELYIEING ZIZIO-CUOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Orig an, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.
Z I Z I 3-U J within 72 ho jiene. r than "netur	Completed	15. Decedent's (Specify only highest (Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most	of workin	ng		of Business/Ind	dustry
VIZING , would be filed Mental Hyger brked other atic event,	To Be C	17. Father's Name (First, Middle, La Dennis James N	st) Nahoney			18. Mother Maudi		(First, Middle, Robinso		mame)	
mand 2 sho leath and m 27 is mu		19a. Informant's Name/Relationship Annamaria Sokel	-daughter	164		Hill F	Road		s Fer		st Va.25425
Dalumore, Dermit Pages 1 ar Department of Hea mportant: If Item	2	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe	city) Ga	ate of 1		metery	y 4/2	24/2006	Silv	er Spri	ng,Maryland
Physicia /Medica Examine	n al	shoot or hear failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused the dealty one cause on each line. Vulvar Ca Due to (or as a conse Due to (or as a conse C	ath. Do not en	ter the mode of dyin					e, Mary	Approximate Interval Between Onset and Death
Geath certifical death certifical e attending physical for use as the	Physician/Medi		23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3[□Ectopic pregnancy □ Other (specify) _	,			230	1. Date of delive Month	ery Day Year
ords, F.O. requires that the een signed by th hould be detache	۾	Part II. Other significant conditions	contributing to death but not re	esulting in the t	underlying cause giv	en in Part I.		10	bacco use		ne cause of death? eably 4 ⊟Unknown
The lare to the la	Completed							24a. Was autop perfor 1 \(\text{Yes} \)	med?		psy lindings available mpletion of cause of 2 No
UIVISION OF VITAIN To the Hospitel or Attanding Physicien: The within 24 hours after death. To the Funeral Director: After this certificete completely filled in by the funeral director, pag	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 No Hospice 1 No Hospice 1 No No No No No No No									Mospice
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)						28f. Location (S City or Tow		Number or Rura	i Route Number,
ne Hospite n 24 hours ne Funera	edicai (Physician: To the best of my kaminer: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at the tir evestigation, in my o	ne, date and pinion, deat	d place, a	and due to the o ed at the time, o	cause(s) an date and pla	id manner as s ace, and due to	tated. o the cause(s)
To the some	×	29b. Signature and title of dertifier	W m	115	29c. Licens D35					signed (Month, 21, 20	-
		30. Name and address of person with Joseph Kaplan, N	1.D. 6001 Munca	aster M	ill Road	Rockvi	ille	,Maryla	nd 20	855	
Regi	State strar	31. Date filed (Month, Day, Year) APR 2 1	2006 32. Pegistrar's Sig	nature	miles						

		•	1 - For State of Maryland / Department	artment of Health and M tificate of Death		piene 005	14342			
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death			
	Physicia		Richard H. Watson, Sr.		Month 4	20 2006				
5	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	ath			
	LXaman	Ŭ.	William Hill Manor, Inc.	Easton		Talbot				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $216-12-5230$ 1×10^{-1} 1×10	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 1 Month Bay	Xexp1	rthplace (State or Foreign country)			
-			Usual Residence of Decedent				Pa.			
	yland	. [10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits			
	a-f s	cto	Md Talbot Easton				1X Yes 2 No			
	s with the	I Director	10e. Street and Number 501 Dutchmans Lane	10f. Zip Code 21601	1	I0g. Citizen of What 0 USA	country?			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinatmist is rividified at	by Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.			
ŏ	2 hou	led	15. Decedent's Education 16a. Decedenting 16a. Decedentin	tent's Usual Occupation		16b. Kind of Busines	s/Industry			
7	nin 72	Completed	(Specify only highest grade completed) (Give life. Sementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ng	Printing	r			
212	d with	E O	12 years Prin	ter		rrrnerne				
5	e file al Hy l othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		Maiden Surname)				
<u> a</u>	should be nd Mental marked c umatic ev	10	Claude Musser Watson		n Mays					
Maryland 21215-0036	nd 2 sho lith and 27 is mu		19a. Informant's Name/Relationship (<i>Type, Print</i>) Michelle B. Watson (daughter)	ng Address (Street and Number or Run 3508 B. Rogers	Ave., E	Ellicott	City, Md.			
<u>6</u>	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City of	r Town, State 3			
Ë	Page nent o int: If		1 Burial 2 K Cremation 3 Hemoval from State	Crematory 4-23	,2006	Dover, D	e.			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 ti any injury or other tra ance.		21. Signature of Funeral Service Licensee	Name and Address of Facility Carroll Hurle						
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	 O. Box 518, St er the mode of dying, such as cardiac 	or respiratory ar	naels, Mo rest,	Approximate			
	Physician /Medical	š¢ 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence):	two Heart Fo	helure		Interval Between Onset and Death			
П	Examiner		Grand Desert With Jan Gran Crop 1042							
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):							
	acutec ind transi	Examiner	Cause (Disease or Injury that initiated events c.							
8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):							
87	physi the b	dical	d							
Box 6	that the death certific ed by the attending p detached for use as '	Physician/Me		Ectopic pregnancy		23d. Date of d Month	eliv ery Day Year			
0	he de the a	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)						
s, P.	w requires that the s been signed by th should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did to		to the cause of death?			
ord	requir een s nould	ted	Dicher Mall	<u></u>						
Vital Record	elaw hasb	Completed	- Daver - S. Millinis			sy prior to meda death	autopsy findings available completion of cause of			
tal		O	25. Was case referred to medical	26. Place of Deat						
>	ys diib	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Ho	me 5 Resid	lence 6 Other (Sp	ecity)			
n of	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending 28a. Date of Injury (Month, Day Year) 1 ☑ Natural 5 ☑ Pending	f 28c. Injury at Work?	28d. Describe h	ow injury occurred				
30	Attending in death.	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No						
Division	I or Att after d Direct I in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Tow	Street and Number or . vn, State)	Hurai Houte Number,			
_	ospita hours uneral ly filled	ledical C	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the ored at the time, or	cause(s) and manner date and place, and d	as stated. ue to the cause(s)			
	To the Howithin 24 To the Forcemplete	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)			
	T W C		Las III Man	DOWN.		4/2/1	\ C			
			30. Name and address of person who completed cause of death (Item 23 (Type,	Print)		(0			
l'	0 +W	A	+ Control of the cont	tchmans Lane, 1	Easton,	Md. 216	01			
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	20						
				Mic.						

Roger Owen Whitmore, Jr.

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

1. For State Certificate of Death Rea No Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Time of Death Physician/ April 23, 2006 0348 hrs Medical Examiner Owen Whitmore, Roger 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington Washington County Hospital 8. Date of 8 irth (MM/DD/YYYY) 9. 8 irthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) Mary land 49 1XXM 2 09/16/1956 220-64-7073 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location any 1 Yes 2 X X No 28a-f show Maryland Washington with the Maryland <u> Hagerstown</u> Director 10g. Citizen of What Country? 10e. Street and Number 10 21740 16947 Alcott Rd items 23a 14. Race - American Indian, 8lack Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. death v Armed Forces? 1 Never Married 2 XX Married Yes 2 XXNo If Yes, Give Year Yes 2XX No specify: after 3 Widowed Divorced Specify. White "natural" ģ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other than the Medical MD 21215-0036 Research and Development Specialist | Cold Storage Door Manu. Pages 1 and 2 should be filed wi Iment of Health and Mental Hygien tant: If item 27 is marked other 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Roger Owen Whitmore.

19a. Informant's Name/Relationship (Type, Print) Grace Marie Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin L. Whitmore - Wife 16947 Alcott Rd. Hagerstown, Maryland Maryland 21740
20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) Burial 2 XXCremation 3 Removal from State rtant: Smithsburg Crematory | April 27,2006 Smithsburg. Maryland Donation 5 Othe Signa, re of Fu Osborne drumer Home, P.A. 425 S. Conococheague St. Williamsport, Maryland the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complication failure. List only one cause on each line. Physician Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes Yes 2 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 Residence 6 Other After this 1 🗸 Yes 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending after death Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l 29d Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number April 23, 2006 O.C.M.E. erso who comple ause of death (Item 23a) 30 Name and address Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD 5H-3 31. Date filed (Month, Day Year) 32. Redistrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Trud 2006 18, 2006 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner nesapeake Woods anby; da Dorchester Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** 1 M 200 F Days Hours Months 03-552 Jan. Director 8 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or tems 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once. 1 Nes 2 No **Funeral Director** Dorchester Vienna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code (satewal 218 USA ean 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 10 No 1 Yes 2 III
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 200 No Specify: Be Completed by Black 3 12 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Processing Line 12 Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) uther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) orraine Vienna MD. 21
20c. Location City or Town, State Obway Gateway 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley Cemetery 06 4 □ Donation 5 □ Other (Specify) Vienna 2. Name and Addres of Facility 21. Signature of Funeral Service Licensee Henry Funeral Home 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. MD.21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain **Physician** nastac 0 AMIC Dyndrome YPAC. /Medical Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 🗆 Yes ete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 X No 3 Probably 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Lutection certificate Anemia 1 Yes To the Hospitel or Attending Physicien: After this certification, funeral director, Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 Hospital: Other: Wursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day

me and 615

address of pe

Cr

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DIU,

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of	Maryland / De	partment of I			ental Hy	/giene	2000	6	14345		
	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Da	ıv Y	'ear	3. Time of Death		
	/Medi		Elda Y. Arce						May	4, 2	006		8:15A M		
	Examir	ner	4a. Facility Name (If not institution,			4b. City, Town,		of Death			. County of				
	Francis		10937 Broad Gr 5. Social Security Number		C. e . Age (In yrs. last birthda	Potoma v) If Under 1 Year		24 Hrs.	8 Date of Si	idh	Montg		ry place (State or Foreign		
Н	Funeral Director		079-56-8670	1□ M 2XF	58 Yrs.	Months Days		Min.	8. Date of Bi (Month, D Octobe)	ay, Year	947	Cour	ntry)		
	D .		Usual Residence of Decedent												
	arylar ehow	_	10a, State 10b. County Marvland Montgo		10c. City, Town or							1	Od. Inside City Limits		
	the M	Directo	Maryland Montgo	mery	Potoma								1 ☐ Yes 2 ☒ No		
	ath with	ral Dir	10937 Broad Gree			10f. Zip Code 20854				Unit	tizen of Whate		•		
Maryland 21215-0036	72 hours after death with the Maryland "naturel", or Itams 23a or 28a-f ehow idical Examinar must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Ford	2 ANO	3. Was Decedent of I If Yes, specify Cub		igin? (Spe n, Puerto f Peruv		0-	14. Race - Black, Specify:	White,	etc.		
5-	72 h natu	ete	15. Decedent's (Specify only highest	Education grade completed)	(Gi	cedent's Usual Occup ve kind of work done	during mos	t of workir	na	16b. K	(ind of Busin	ness/Inc	dustry		
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	. DO NOT use retire sician	rd)			LT	lospit	- 1			
9	Hygi Hygi ther int, I		17. Father's Name (First, Middle, L.		Tily	SICIAII	18. Mothe	er's Name	(First, Middle						
au		To Be	Victor Arce						morro	o, majoon					
ary	es 1 and 2 should b of Heelth and Ment I Item 27 is marked r other traumatice		19a. Informant's Name/Relationshi		19b. Ma	iling Address (Street	and Numbe	er or Rura	i Route Numb	per, City o	or Town, St	ate, Zip	Code)		
Σ	and 2 eith a n 27 is	1	Peter R. Hammond	comptant gramatons as other place)											
ore	of He of He fitem roth		20a. Method of Disposition	and of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
Ë	Pag ment ant:		4 □Donation 5 □ Other (Sp.	Donation 5 Other (Specify) Montgomery Crematorium 2006 Bethesda, Maryland Note: 1 Other (Specify) Montgomery Crematorium 2006 Bethesda, Maryland 1 Other (Specify) Pumphrey Fineral Home											
Baltimore,	permit. Pages: Depertment of F Important: if its any injury or ot		21. Signature of Funeral Service L		00092 R	22. Name and Addre OCKVILLE, OCKVILLE,	Inc. Mary	y ₃₀₀ b 1and	West A 20850	Pum 2805	phrey	Fu Av	neral Home enue		
ı			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that can	used the death. Do not each line.	enter the mode of dyi	ng, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Between		
	Physician		tmmediate Cause (Final disease or condition	Sep	sis								Onset and Death 1 week		
	/Medical Examiner		resulting in death)	Due to (o	rasaconsequence of): astatic Gas	tric Canc	or					6	months		
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ر هر	icate be executed physician and s the buriel-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):									-			
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P.O. Box	thet the death certificate be executed sed by the ettending physician and detached for use as the buriel-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								Date of delivery Month Day Year				
	s thet	by Pt	Part II. Other significant condition	s contributing to dea	th but not resulting in the	underlying cause giv	ven in Part I.		23e. Did	tobacco	use contribu	ute to th	e cause of death?		
rds	w requires been sign should be								1 🗆	Yes 2	⊠No 3	☐ Prob	ably 4 Dunknown		
Division of Vital Records,	a a ca	Completed							24a. Was	psy	24b. We	re auto	psy findings available inpletion of cause of		
a F	T ege									ormed? 24 No	dea 1 □		2 □ No		
Zi.	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		ent 3 DOA Ott			Check only						
ō		2	1 ☐ Yes 2 € No 27. Manner of Death	1 ☐ Ing 28a. Date of (Month)	oatient 2 ER/Outpati	BILL JUDON	4 () 140		ne 5 Res			(Specify	"		
on	Attending r death. ector: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	No 2		now angu	y occurred								
Visi	or Atten efter deat Director: In by the	Hice	3 Suicide 6 Could not be 4 Homicide determined 4 Homicide determined building atc. (Specify).									l Route Number,			
ā	tal or	Certification:	building, etc. (Specify) City or Town, State)												
	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	edicai											ated. the cause(s)		
	To the within 2 To the complet	×	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										Day, Year)		
•	0.		Laurence audin Dayle up D23809 May 4, 2006												
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurence Doyle, M.D. 22 South Green Street, Baltimore, Maryland 21201												
	Sta	to	31. Date filed (Month, Day, Year)			1	art1mo	ore,	maryla	ına	2120	. 1	7.1500		
	Registr			3 2006	gistrar's Signature	persi.									
011		201	The second secon	45							- 111		ALCOHOLOGY CONTRACTOR		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 6, **Physician** HELENA MARIA BURGNON 2006 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1604 BEAR PAW LANE HANOVER

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea
NOV. 3, 1 HANOVER ANNE ARUNDEL 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🗓 F 92 212-78-8571 Director 1913 SLOVAKIA Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d Inside City Limits the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL HANOVER 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1604 BEAR PAW LANE 21076 UNITED STATES or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 □ Divorced "natural". WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe eny injury or other traument 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALEXANDER FIKAR MARIA SKERES 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAELA BURGNON / DAUGHTER 1604 BEAR PAW PATH, HANOVER, MARYLAND 21076 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Security) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ARLINGTON NAT. CEM. ARLINGTON, VIRGINIA 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, 21. Signature/of Funeral Service Licensee once. 21061 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the attending physicien Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 💆 No Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of ca 29c. License number 29d. Date signed (Month, Day, Year) D 21438 MAY 8, 2006 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person MICHAEL J. LAPENTA, M.D., 445 DEFENSE HIGHWAY, ANNAPOLIS, MARYLAND 21401 31. Date filed (Month, Day, Year) MAY 0 8 32. Restrar's Signature State 2006 Registrar

06-02354 Milton Bull

Please Type or Print in Black Indelible Ink

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Physicia Medical Examir	n/	1 Decedent's Name (First, Middle,Last)	Bull			Date of Death	Day Year	3 Time of Death 0848 hrs	
		4a. Facility Name (if not institution, give street of Veterans Administration Hospita	,	4b. City, Town, or Local		April 3, 200	4c. County of Death		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimore City If Under 1 Yeer If	Under 24Hrs.	8. Date of Birth		hplace (State or	
Director		719-52-7921 1XM 2	JF 55 Y	rs. Months Days H	lours Min.	3-19	- 1951 Foreig	n untry) MARYLANK	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits	
rlaryland 28a-f show	ē	MJ	Bott.	MORE				1 X Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once,	Director	132\$ North Che	Her St	10f. Zip Code 21213	3	10g	Citizen of What Coun	itry?	
th with the cems 23a	uneral	11. Marital Status 12. Wa	as Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mex	Origin? (Spec		14. Race - Americ White, etc.	can Indian, Black,	
after des	by Fur	3 Widowed 4 Divorced if Yes, G	Yes 2 No	Yes 2 No spe		,	Specify: BL	ock	
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036 vithin 72 ene. er than	ompleted	Contain (0-12)	2 A	Rea Supe	PR/501	R	Sanit	DRIAL	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "matural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) SAMES BULL			other's Name (F		aiden Surname)		
e a & e		19a. Informant's Name/Relationship (Type, Prin	(t) 19b. Mail	ing Address (Street and	Number or Rur			Zip Code)	
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Baltimo permit. Page Department of Importants injury or ott		21. Signature of Funoral Service Coursee	22	Name and Address of Fa	acility 163	an Cha	no De	No md.	
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Sion of Vital Rec Attending Physician: The r death. ctor: After this certificate by the funeral director, page	o Be	25. Was case referred to medical examiner? 1 V Yes 2 No	✓ Inpatient 2 ER/Outpatie	[Othor	eath (Check online) Mursing H		esidence 6 Other:		
n of ding Ph.	no.	27. Manner of Death 1 Natural 6 Death	Date of Injury (Month, Day, Year) 28b. Time o	1 Ves 2		d. Describe ho	w injury occurred		
E & & & E & E	ertification:	Accident Pending Investigation 9/2/1982 9:14 pm 1 Yes 2 X No Subject shot 3 Suicide 6 Could not be determined Subject shot Subj							
Divis Hospital or At 24 hours after d Funeral Direct tely filled in by	O	4 X Homicide determined (Sp.	ecify) unk			altimore.	MD		
Di To the Hospital of within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner:On the	ne best of my knowledge, death occ basis of examination and/or investig nner stated.						
	Σ	29b Signature and title of certifier	000.	29c. License num O.C.M.E.		i .	29d. Date signed <i>(Mon</i> April 6, 2006	th, Day.Year)	
,	ŀ	30. Name and address of person who complete					, , , , , , , , , , , , , , , , , , , ,		
Str	ate	/12	ssistant Medical Examiner 32. Registrar's Signature	111 Penn Street,	, Baltimore,	MD 21201			
Regist	rar	31, Date filed (Month, Day, Year) MAY 0 8 2006	a si spone						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4,2006 Linda Elizabeth Britt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TIMORE 13ALTIMORE
If Under 1 Year | If Under 24 Hrs. SAINT 161055 PITAL 8. Date of Birth (Month, Day,) June 10, Social Security Number Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Year) 948 Min. 1 ☐ M 2 🖾 F 57 Mary Land Yrs Director 218-48-1091 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland ment of Health and Mental Hygiene.

Bent: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow ury or other traumatic event, the Medical Exactly at most less requiled at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits N/ABaltimore 1 XYes 2 No Directo MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 2306 Brohawn Ave U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 20XNo Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Accounting Clerk Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noble John Ensey, Sr. Catherine Elizabeth Stubbin 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if Itam 27 is eny injury or other trau Billie Everette Britt, Sr. 2306 Brohawn Ave Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Park

Date 20c. Location - City or Tow 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensu 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sonset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.
To the Funerel Director: Attent this certificate has completely filled in by the funeral director, page 2 autopsy performed? Yes 200 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who mpleted cause of death (Ite 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		For	State of Maryland /			ntal Hygie	ene, a a c	11010
		1 - State Registrar		Certificate of D	eath	Reg	1. NO. UUD	14347
		1. Decedent's Name (First, Middle, Last,			2.	Date of Death		3. Time of Death
Physic		JEAN	BUTLER			Month 4	Day Year	1007 AM
/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or L	ocation of Death		4c. County of De	
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Funeral		5. Social Security Number 6. Sec			If Under 24 Hrs. 8	Date of Birth	9.8	irthplace (State or Foreign
Director			M 2X7 72	Yrs. Months Days	Hours Min.	(Month, Day, Y	ear) (Country)
		Usual Residence of Decedent				1/24/	1933 M	ARYLAND
ylan		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
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Balt permit. Depertu Importa any inju		21. Signature of Tyneral Service Licens	96/	22. Name and Address	of Facility HOWE	II. FIIN	JERAT, HO	OME 21207
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Trem #4bPer Phy &10c P Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 29, 2006 Physician Sarah Higgins Brandt 1:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 'Hyattsville Adelphi Prince George's 1836 Metzerott Road Apt. 1121 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth October 23, 1926 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 073-22-6362 79 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23e or 28a-f ehow the Medical Examinar must be oblitied at 1 ☐ Yes 2 No Hyattsville Prince George's Adelphi. Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 1836 Metzerott Road Apt. 1121 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 ∭XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry aith and Mental Hygiene. 27 le marked other then 'n traumailc event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) other then U.S. Government Records Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Thornton Michael Joseph Higgins ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1195 South Forest Denver Colorado 80246 Rita Higgins/Sister-in-law Health in Item 27 I other tra 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite eny Injury or ot once. Mt. UTvet Cemetery Wheat Ridge Colorado 5/13/06 4 ☐ Donation 5 ☐ Other (Specify) Christina L. Hilton 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Christina L'Hitton Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myscardipl **Physician** House /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit ₽ox 68760,→ Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 1 ☐ Yes 2 € No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy rmed? 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) ၉ 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funerel Dire 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

JOSEPH

MAY 0 8 2006

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31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Ma	ilylanu / I		rificate of				Reg. No.	UUD	435	
	Physici	an	1. Decedent's Name (First, Middle, Last	- 1	1	•			2.	Date of Dea Month	ith Day		3. Time of Death	
	/Medic	al	Edith	Brull			4b. City, Town,	!+:		May	4	2006 County of Dea	1:14 PM	
	Examin	er	4a. Facility Name (If not institution, give	.1 10	inter		Rande		orbeam		40.		ALTIMORE	
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last bi	irthday)_ Yrs.	If Under 1 Year Months Days	If Unde		Date of Birt Month Day 03/25	/ 191	.9 9. Bi	rthplace (State or Foreign ountry) MD	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Loc	ation						10d. Inside City Limits	
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	ath wi	ralD	1 GRISTMILL COUR					2120					USA	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Hatth and Mental Hyglene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f ehow other traumatic event, the Maclical Examiliar mast be nutilized at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:			as Decedent of Yes, specify Cub			y Yes or No- ean, etc.)		14. Race - Am Black, Whi Specify:		
ָה ק	72 h	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a	(Give k	ent's Usual Occu and of work done	durina mo	st of working		16b. K	ind of Business	s/Industry	
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א ב	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		1			18. Moth	ner's Name (F	First, Middle,	Maiden	Sumame)		
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ם Dall	permit. Depart Import any Inj		21. Signature of Funeral Service Licens	when			Name and Address 900 REIS					& BROS SVILLE	, MD 21208	
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	20		30. Name and address of person who	completed cause of de	1 11		Print)	100	0	-10-11	1	LA =	2006 yland 1133	
	<i>0</i> ~		31. Date filed (Month, Day, Year)	32 Begistra	est H	ospi	tal Ce	n7ur	Kar	nall5	100	n Mar	yland 1133	
	Sta Regist		MAY 0 5 2006	La de la constitución de la cons	# Z	Acres 1	60						ł	

ORIGINAL

			For State Registrar	State of Marylan		artment of F		nd Mental Hy	giene Reg. No	06	14352
	4,		Decedent's Name (First, Middle, I	.ast)				2. Date of D	aath	Year	3. Time of Death
	Physici /Medio		LEO JOSEPH CAMPI	ON				MAY 4,	2006	Tear	5:00 P M
	Examin		4a. Facility Name (If not institution, g	,	m A m T O Y	4b. City, Town, o		Death		inty of Death	
L			NORTH ARUNDEL HE 5. Social Security Number 6	ALTH & REHABILI Sex 7. Age (In yrs.		GLEN BUI	If Under 24	Hrs 9 Date of Bi	1	NE ARU	
1	Funeral Director		216-16-5966	12 M 2□F 82	Yrs.	Months Days		Min. (Month, D	4,1923	MARY	place (State or Foreign ntry) 'LAND
	D		Usual Residence of Decedent						.,-,-		
	arylar ehow	_	10a. State 10b. County		y, Town or Lo	cation				1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	ectc	MARYLAND ANNE AR 10e. Street and Number	UNDEL SEVE	RN	10f. Zip Code			10a Citizan	of What Cou	
	Mith Ba or	Funeral Director	244 SHEILA K CT.			21144				D STAT	-
	death ma 2:	Jera	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H	ispanic Origir	n? (Specify Yes or N	o- 14. F	Race - Ameri	can Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itema 23a or 28a-f ehow event, the Madical Exeminar must be notilled at	by Fur	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		ryes, specify Cuba 1 □ Yes 2 🗓 No	Specify:	Puèrto Rican, etc.)		Black, White, ac <i>ify:</i>	
21215-0036	tural	ed b	15. Decedent's			ient's Usual Occup	ation		16b. Kind o	WH.	ITE
Ç12	within 72 ene. than "nal	Completed	(Specify only highest s Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	durina most o	of working	Tob. Tand o	, businessani	is a state of the
212	giene giene er the	mo.	12	College (1-401 5+)	IRON	WORKER			CONST	RUCTIO	N
Maryland		Be	17. Father's Name (First, Middle, La EDWARD GEORGE CA					s Name <i>(First, Middle</i>	, Maiden Sun	name)	
<u> </u>	s 1 and 2 should be if Health and Mental Item 27 is marked oother traumatic eve	P	19a. Informant's Name/Relationship		19h Mailir	Address (Street		Or Rural Route Numb	or City or To	um Stato Zin	a Codol
<u>8</u>	and 2 sho ealth and m 27 is m		VIRGINIA M. SHUP		1	-		SEVERN, MA	-		
ē,	s 1 ar if Hea item other		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place	1	AY 7,		on - City or To	
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Denation 5 ☐ Other (Spe	Hemovai from State	-	EMATORY,		2006	CATON	SVILLE	, MARYLAND
Baltimore,	permit. Pages Department of I Important: If its any Injury or o		21. Signature of Fun ral Service his	ensee	K	IRKLEY-RU	DDICK	FUNERAL H	OME, P	.A.	21061
	_		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the death						1E, FID	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ly one cause on each line.							Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):								
	Examiner	_	Sequentially list conditions, ff any, leading to immediate Due to (or as a consequence of):								
1	bed Isit	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury								
/	s be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
8/60	cate be executed physicien and the burial-transit	dicai		d							
		Medi	IF FEMALE:								
x o n	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3□	Ectopic pregnancy				Date of delive	ery Day Year
	at the death by the atte	Physician/Me	1 Yes 2 No	4☐ Pregnant at time of d	eath 5	Other (specify)				Wichigh	Day (bai
2	res that t igned by be detac		Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
rds,	w requires that been signed b should be deta	ed by	+					_ 10	Yes 2□No	o 3 ☐ Prot	pably 4 Minknown
Hecord	S C S	Completed						24a. Was		b. Were auto	ppsy findings available impletion of cause of
_	The ete h page	E O						perf 1□ Yes	ormed? 2. No	death?	2 No
Vital	Phyaician: this certific ral director,	Be (25. Was case referred to medical examiner?	Ussainel		104		f Death (Check only	one)		
0	Phy this ald	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatien 28b. Time of		4 or Nurs	ing Home 5 Res			5)
	Attending I r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		now injury oc	cuired	
		Certification;	3 Suicide 6 Could not	be One Disco of Injury At he	ome, farm, str	eet, factory, office		28f. Location	Street and Nu	ımber or Rura	al Route Number,
בֿ	ital or A irs after rai Directed in Dy										
	To the Hoepital or Mithin 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying 2/ Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) and date and place	manner as s ce, and due to	stated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
•			· YA	1		D38	5958		5/5	106	
	1		30. Name and address of person wi	completed cause of death (Item	23a) (Type,	Print)	, ,	2	00	1	e MD2106
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture (rain H	19 MOR	y Sw	elen 1	Symu	C 1902/06
	Registr			006	K. As	all	V				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 30, 2006 John Thomas Cool<u>ahan</u>, Jr. 6:50PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Violetville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. | 15, 1936 3624 Hineline Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□F Months Days 70 Yrs. Director 218-32-5493 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 North Avenue 21227 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐X/es 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Experimentance. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Construction Tile Setter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Thomas Coolahan, Sr. Lillian Mae Stauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Burroughs Sister 3624 Hineline Rd., Violetville, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 5-4-2006 Woodlawn, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ADVANCED DEMENTIA, VASCULAR THREE YEAR /Medical Due to (or as a consequence of): Examiner -TIPLE STROKES MUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TWENTY Due to (or as a consequence of): Examiner YEARS The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSTEOMYELITIS RIGHT HEEL INSULIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DEPENDANT DIABETES MELLITUS WITH 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? VASCULOPATHY ESSENTIAL HYPERTENSION 1 Tyes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea... 1 SNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 determiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Konalleran D18362 5/1/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 3455, Wilkens Ave. Suite Lp. Balto. Md 21229 Komal k. Dang 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 8 2006 Registrar

		1 - For State Registrar	State of Maryla		artment of I rtificate of		and Mental Hy	giene Reg. Nõ.		14354			
Physicia /Medic		1. Decedent's Name (First, Middle, Last, GEORGE M. CAMPBE					2. Date of De MAY 2,		6 Year	3. Time of Death 6:53p M			
Examin Funeral		4a. Facility Name (If not institution, give JOSEPH RITCHIE F. 5. Social Security Number 6. Se	OSPICE	s. last birthday)	If Under 1 Year	IMORE If Under	24 Hrs. 8. Date of Bi	rth	N/A 9. Birthp	place (State or Foreigr			
Director		214-30-6587 Usual Residence of Decedent	лм 2 П F 71	Yrs.	Months Days	Hours	Min. (Month, Di			LAND			
Be-f ehow	Director	MD. CALVERT		ORT REF	UBLIC					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
23a or 2	rai Dire	10e. Street and Number 1726 GRAYS RD.			10f. Zip Code 206	76		-	SA	ntry?			
within 72 hours after death with the Maryland sne. than "natural", or items 23a or 28e-f ehow than "Nadical Evantinet rivet by notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Ori an, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: BLA	etc.			
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire CRVISOR	during most	t of working		nd of Business/In	dustry			
ild be filed fental Hygi rked other lic event,	To Be C	17. Father's Name (First, Middle, Last) JAMES T. CAMPBE	LL TO				r's Name (First, Middle TTIE KING	, Maiden	Sumame)				
ges 1 and 2 should be t of Health and Mental If item 27 is marked o or other treumatic eve		19a. Informant's Name/Relationship (T) GEORGE M. CAMPBE					or or Rural Route Numb PORT REPUBL						
Pa men ant:		20a. Method of Disposition A Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State C	Place of Dispo cemetery, crea ARROLL	osition (Name of matory or other pla S CEMETE	сө)	Date 5-8-2006	20c. Lo	ocation - City or To				
permit. Departr Importe any nji		21. Signature of grana Survice Lieuns	CLADYS SEWE	1			SEWELL FUN CH RD. PRIN			, MD 20678			
Physician /Medical		23a. Part 1. Enter the dis lasts or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prosta TE CAUCET Due to (or as a consequence of):											
physicien and physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, reading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):											
death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		4	23d. Date of delive Month	ery Day Year			
S S S	þ	Part II. Other significant conditions con		ise contribute to t	he cause of death? pably 4 _Unknown								
The ate h page	Completed						24a. Was auto perfi 1 □ Yes		24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available impletion of cause of			
Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 21	☐ ER/Outpatier	nt_3 DOA	105	of Death (Check only rsing Home 5 ☐ Res		6 ther (Specif	m HOSPICE			
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ryat rk? ∣Yes 2 🗆 I	28d. Describe how injury occurred									
ital or Att													
the Hospital hin 24 hours a the Funerel I upletely filled	29a. Certifier (Check only one) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To the comple	W	29b. Signature and title of certifier	dur m)	29c. Licen		7/	29d. Dat	e signed (Month,	Day, Year)			
25		30. Name and address of person who a	RIS HNAM	182	Print) N. EI)TAZ	257 6	ALT	1 mol	EM24			
Sta Registr		31. Date filed (Month, Day, Year)	39 Registrar's Sig	nature	all .								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician LONDON CANTY 10:00P MAY 01 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENESIS-CATONSVILLE COMMONS CATONSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 CAROLINA Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2□ F 81 Yrs. S. Director 218-76-2659 08/09/1924 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** or 28a-f show XXYes 2 No Director MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "naturel", or iteme 23s or the Medical Examiner must be 2848 MULBERRY STREET 21223 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ BLACK 3X Widowed 4 ☐ Oivorced Compieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 3RD DISABLED other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 21 is marked oth any injury or other taumatic event once. 17. Father's Name (First, Middle, Last) Be MUSKER CANTY, CHARLOTTE JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 MOSHER STREET, BALTIMORE, MD 21217 LOTTIE CARROLL / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 5/06/06 LANSDOWNE, ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD or the disease, or complications that caused the or art failure. List only one cause on each line. Approximate Interval Between Onset and Death ed the death Do nut enter the mode of dying, such as cardiac or respiratory arrest, Immediat Cruse (Final disease condition **Physician** WE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events Qualto for as a consequence off Examine or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Cluknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the note after death.

within 24 hours after death.

To the Funeral Director: Alt. 5 Pending 1 Tes 2 No investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Name and address of completed cause of death (Item 23a) (Type, Print) Frederick Rd. Ceforguille, up 2/228 009 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

			For State Registrar	State of	Marylar				leaith and M Death		ieņe	5	14356	
	Physicia	an.	1. Decedent's Name (First, Middle, Last,							Date of Deat Month		Year	3. Time of Death	
	/Medic		Bernard		ank	Custo				May 3,	2006		2:09 A. M	
	Examin	er	4a. Facility Name (If not institution, give	street and numb	er)				r Location of Death		4c. County o		20	
	See See	d'	Gilchrist 5. Social Security Number 6. Sec	7.	Age (In yrs	. last birthday)	If Under		II Under 24 Hrs.	8. Date of Birth	Balt	9. Birth	place (State or Foreign	
	Funeral Director			X M 2□F	80	Yrs.	Months	Days	Hours Min.	July 15	1925	Pe	enn.	
_	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	ocation						10d. Inside City Limits	
	faryla shov	or	Maryland N/A			Baltimo		itv					1 Yes 2 □ No	
	the N	rect	10e. Street and Number	·			10f. Zip			1	0g. Citizen of Wi	nat Cou	ntry?	
	h with	ai Di	6105 Walther Ave	nue			2.	1206			U.S.A.			
	ems ?	iner	11. Marital Status	12. Was Decede	es?	J.S. 13.	Was Deced	dent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ White,	can Indian, etc.	
36	is after death with the Marylan i, or items 23a or 28a-f show	y Fu	1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give	□ No		1 🗆 Yes				Specify:	Wh	nite	
Ş	filed within 72 hours after death with the Maryland Hygione. ther than "naturel", or Items 23a or 28a-f show int, the Medical Exameter must be notified.	Completed by Funeral Director	15. Decedent's Edu	Year or Date	es: WW	16a. Dece	dent's Usua	al Occup	pation		16b. Kind ol Bus	iness/In	ndustry	
215	hin 72 an "ne Medis	piet	(Specify only highest grad	e completed) College (1-4	or 5+)	(Give	kind of wo DO NOT us	rk done se retired	during most of work d)	ing				
21,	filed within Hygiene. other than ont, the Me	Сош	12	4		Elec	ctron:	ic E	ngineer		Aberdee		.G.	
Marvland 21215-0036	d tal	Be	17. Father's Name (First, Middle, Last) Bernard		Cus	todero	Sr		18. Mother's Name	•	Maiden Surname Sac			
2	2 should be f n and Mental h is marked of raumatic eve	To	19a, Informant's Name/Relationship (T)	rpe, Print)	uus			(Street	and Number or Run				o Code)	
			Mrs. Nancy Custo	dero - W	life					Baltimor				
Baltimore.	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from St	20b.	Place of Dispo cemetery, crea	osition (Nar matory or o	ne of other plac	сө)	Date	20c. Location - C	ity or To	own, State	
Ë	permit. Pages Department of h Important: If ite ony injury or of		4 ☐ Donation 5 ☐ Other (Specify)			111			metery 5/	127 - 208	Baltimo			
Ba	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Licens	e t					ess of Facility Ba Ruck, In	ltimore,				
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0 6	Physician: this certific	မ	1 ☐ Yes 2 € No			ER/Outpatie			ner: 4 Nursing Ho				ty) HOSPICE	
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ade	or Attending after death. Director: After in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,											
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7	To th To th	M	29b. Signature and title of certifier	myte	lile	y; cers	290	C. Licens	se number		9d. Date signed			
	10		30. Name and address of person who c	ompleted cause	of death (fite		7	DIN	N. CHAR	LES STR	CET	f		
	Sta		31. Date filed (Month, Day, Year) MAY 0 8 20		gistrar's Sigr	nature					/			
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		1 - For State Registrar	State	of Maryla	•	artment of rtificate of			lental Hy	giene Reg. No.	006	14357	
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Exam		4a. Facility Name (If not institution 122 Liberty S	-	imber)		4b. City, Town, West	or Location			4c. C	County of Death		
Funera Directo	_	5. Social Security Number 215-52-7310	6. Sex 1 ☐ M 2 ☐ ▼F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bir (Month, D	rth Year 19	9. Birth	place (State or Foreign etry)	
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD C	arroll		City, Town or Lo Westmin							10d. Inside City Limits 1 Yes 2 No	
h with the 13a or 28a	ai Director	10e. Street and Number 122 Liberty S	treet			10f. Zip Code	21157			10g. Citize	en of What Cou USA	ntry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23s or 28a-f show eny Injury or other treumatic event, the Medical Exercite arms to indiffied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	nied Armed F	ive X No		Was Decedent of If Yes, specify Cul			ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.	
within 72 ho plane. r than "netur	Completed		nt's Education st grade completed College) (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Cosmeto10	during mo d)	st of work	ing		16b. Kind of Business/Industry Personal Care		
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Physiciar /Medica Examine	1											Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit.	dical Examiner	resulting in death) Last Due to (or as a consequence of):											
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S Regis	tate strar	30. Name and address of persor 31. Date filed (Month, Day, Year MAY 0.8	Border		- 1	0 4	١٠.	ene	e we	stru	Jen 11	12006	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20b, perFH, C855, 5/15/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** JOHN 0950 AM DAVIS SR 5 MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE HOSPITAL NORTHWEST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06/27/1940 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F North Carolina Yrs. Director 241-64-0560 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene and of Heatth and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show ary or other traumatic event, I'm Medical Experient must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3627 Courtleigh Drive 21133 U.S.A. Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Port Association Longshoreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen Jones John Davis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3627 Courtleigh Drive, Randallstown, Maryland 21133
ace of Disposition (Name of Date 2005, Location - City or Town, State Ebony Terry / Daughter 20c. Location - City or Town, State
Ellicott City,
Baltimore, Maryland 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition emetery, crematory or ourse, propermit. Pages 1 Department of H Important: If ite any injury or ot once. 1

☐ Burial 2 ☐ Cremation Removal from State 05/13/2006 4 □ Donation 5 □ Other (Specify ature of Funeral Servic 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days Cerchovasculo /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2/2 No certificate has 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death Certification: After Injury 1 Aatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide determined 4 THomicide 24 hours a 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D0059736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 NORTHWEST OLD COURT Mo. (+DSPOTAL DEBLEAU Speake

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0

8 2006

32. Registrar's Signature

			For	e Type or State o			Depa	ırtmen	t of H	lealth a		Copies		_	ible.	With the state of	59
			Stata Registrar 1. Decedent's Name (First, Middle,					tificate	e or u	Jeath		2. Date of D	Reg. h	No.	G.lm	3. Time o	of Death
	Physici /Medic			LII		С.	DEA					Month	1AY	E ,	2866	7:4	1 AM
	Examin	er	4a. Facility Name (If not institution, Saint Josep	h Medic	al	Cente					owso			4c. Count	y of Death Balt		
	Funeral Director		5. Social Security Number 218-52-0641 Usual Residence of Decedent	3. Sex 1 □ M 2XXF	7. Age 7	(In yrs. last t	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D 07-24-	192	6		lace (State try) _IFOR	
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and	9 7 9 5	Be	17. Father's Name (First, Middle, La	•	CHIN							(First, Middle	, Maid MOY		me)		
, Maryland 21215-0036	es 1 and 2 should be for Health and Mental Hitem 27 ie marked of rother treumatic even	2	19a. Informant's Name/Relationship (Type, Print) CHERK S. DEA (HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 8 TEANECK DRIVE, TIMONIUM, MARYLAND, 2109 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition) Date 20c. Location - City or									Code)					
Baltimore,	Pages 1 e		20a. Method of Disposition XIX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	3 □Removal from ecify)	State	20b. Place ceme DULAN	tery, cren	natory or or	ther plac	^{∞)} G. (ate 3-2006					
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		For State Registrar		epartment of Health and Certificate of Death	Reg. I	1 000 14000
Physic	,	Decedent's Name (First, Middle, Last) WILLIAM	GEORGE DORS	СН		
/Medi Exami	A	4a. Facility Name (If not institution, give stri GOOD SAMARITAN NURS		4b. City, Town, or Location of De BALTIMORE C.	eath ITY	4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 065-10-8493 XXI	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 F Months Days Hours W	lin. 8. Date of Birth (Month, Day, Yea 10-29-191	9. Birthplace (State or Foreign Country) 8 MARYLAND
D	Director	Usual Residence of Decedent 10a. State 10b. County MD. BALTIMOR 10e. Street and Number	10c. City, Town	or Location PHOENIX 10f. Zip Code	10g.	10d. Inside City Limits 1 □ Yes 2\(\frac{1}{2}\)\(\text{No}\) Citizen of What Country?
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nin 72	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	163	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Office Manager	working	. Kind of Business/Industry Steam Shipping
be file had othe	To Be Co	17. Father's Name (First, Middle, Last) George	Dorsch	18. Mother's	Name (First, Middle, Maid Mabel Hay	den Surname) /es
or Heal		19a. Informant's Name/Relationship (Type) Mr. W. Gary Dorsch/ 20a. Method of Disposition 1 [★Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Son 371	Mailing Address (Street and Number of 3 Stansbury Mill Disposition (Name of commatory or other place)	Road Phoeni Date 200	ity or Town, State, Zip Code) X. Maryland 21131 b. Location - City or Town, State Stinore, Naryland
Baltimore, permit. Pages 1 ar Department of Hez Importent: If Item any injury or othe		21. Signature of Funeral Service Licenses	In Il	22. Name and Address of Facility RUCK TOWSON FUNE	RAL HOME,INC	1050 YORK ROAD TOWSON MD.21204
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of Vital Physicien: rithis certifica	To Be	25. Was case relerred to medical examiner? 1 Yes XX No 27. Manner of Death XX Natural 5 Pending	28a. Date of Injury 28b.	itpatient 3 DOA Other: 4XXVursi	f Death (Check only one) ing Home 5 Residence 28d. Describe how	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			et and Number or Rural Route Number, State)
Hospite 4 hours Funerel tely filled	edical C	29a. Certifier (Check only one) XXX Certifying Phys	ician: To the best of my knowledge er: On the basis of examination ar and manner stated.	e, death occurred at the time, date and id/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date	se(s) and manner as stated. a and piace, and due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifies	w m	29c. License number 0577	-87- 29d	MAY 3, 2006
7+1		30. Name and address of person who co		(Type, Print) RAVEH BLVD	BALTIMOR	E mp 21239
Poni	State	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	boardes		

			ricașe i	State of Maryla					-	_	3.
		•	For State Registrar	Otate of Maryte		•	te of De		-	Reg. No. 0 0	14361
			Decedent's Name (First, Middle, Last,)					2. Date of Dea	ath	3. Time of Death
	Physici /Medio			Joan Ann D	eWitt				Month 05	03 200	
	Examir		4a. Facility Name (If not institution, give	street and number)	1 1	4b. Cit	, Town, or Loca	ation of Death		4c. County of E	Peath
			tranklin Sou		tal	P	eseac	ue	T	Fall	imore
	Funeral		5. Social Security Number 6. Set 215-28-6733	x 7. Age (in y 3 M 2√2 F 73		Month:		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)
	Director		Usuat Residence of Decedent	7,5					May 8	,1932 N	Maryland
	ylanc		10a. State 10b. County		City, Town	or Location					10d. Inside City Limits
	e Mar	ctor	Maryland Ba	1timore				Colga	te		1 ☐ Yes 2 ² No
	or 28	Director	10e. Street and Number			10f. 2	ip Code			10g. Citizen of Wha	t Country?
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show te Mudical Exempler rust be notified at	rai	7838 Eastdale R			10.111 B		21224			States
	iter de	in.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	10.5.	If Yes, sp	ecify Cuban, M	exican, Puerto	pecify Yes or No Rican, etc.)	Black, V	American Indian, Vhite, etc.
336	irs aff	by Funerai	3€ Widowed 4 Divorced	1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	2 No Sp	pecify:		Specify:	White
21215-0036	2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. l	Decedent's Us	ual Occupation	a most of wor	king	16b. Kind of Busine	
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- '	life. DO NOT	ork done during use retired)	g most or won	King	Baltimor	e County
	filed wi Hygien other th	S	12 Years		C	afeter	ia Work			Schools	5
<u> </u>	be fill stai H d oth	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nam		Maiden Sumame)	
) 😤	should and Men marke umatic	ဥ	Douglas Roloff 19a. Informant's Name/Relationship (T)	una Printl	10h	Moiling Adden	on (Street and A	Number or Pu	Esth	ner Mack er, City or Town, Sta	to Tio Code)
Maryland	C/ (0) -= =	3	Ricky L. DeWitt	(Son)			tdale R			e, Marylar	
	Health tem 27 other tr	1 15	20a. Method of Disposition		Ī	Date	20c. Location - City				
Baltimore,	Pages ent of nt: if i	-	1 ☑ Burial 2 ☐ Cremation 3 ☐ F ☐ Donation 5 ☐ Other (Specify)	temoval from State		Disposition (N , crematory of S Of F	aith Ce:	m. 5/6	/2006	Rossvill	e, Maryland
alti	permit. Depertm Importa any inju	- 1	21. Signature of Funeral Service Licens			22. Name	and Address of	Facility			
ä	Depermine Depermine Important in processing		12.0	· Call		7922	-Ruck F Wise A	uneral ve. Du	indalk,	Dundalk, Maryland	21222
		0	23a. Part1 Enter the disease, or complement failure. List only o	ications that caused the d	eath. Do no						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHF							Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence o	4 6	D: -				
	Lxammer	ایا	Sequentially list conditions,	Due to (or as a cons	4 1		Diseo	se			
	ted	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diabe	100	7-					
	execun n end al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of	i):					
760,	ysicie burie	call		. Hypert	nsi	on					
68	requires thet the death certificate be executed seen signed by the attending physicien end hould be detached for use as the burial-transit	Jedi	IF FEMALE:	11							
Box	ith ce tendii or use	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		3 □Ectopic	pregnancy			23d. Date of Month	delivery Day Year
0.1	e dea the at	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o	of death	5 Other (specify)			Wichan	Day (bar
P.O.	thet the		Part II. Other significant conditions co	ntributing to death but not	resulting in	the underlying	cause given in	Part I.	23e. Did to	obacco use contribu	te to the cause of death?
ds,	S 6 8	Completed by	Auto-immure	- Hepatiti	5				101	res 2 No 3	Probably 4 Unknown
O		iete	•						24a. Was	an 24b. Wer	e autopsy findings available
Re	The law ate has b	E							autor perfo 1 ☐ Yes	rmed) deat	
ita	lan: 'Itifica	0	25. Was case referred to medical				26.	Place of Dea	th (Check only o		163 202110
>	hysic his ce I direc	To B	examiner? 1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	ER/Out	patient 3 🗆 [OA Other: 4	□ Nursing H	ome 5 Resid	dence 6 □Other (Specify)
Ē	ing P	ü	27. Manger of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Ti	ury	28c. Injury at Work?		28d. Describe I	how injury occurred	
Sign	ttend death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	thoma for	M street foot	1 Tes	2 🗆 No	28f Location (Street and Number of	r Rural Route Number,
Division of Vital Records,	or A efter Direction by	Certification:	4 Homicide determined	building, etc. (Sp.	ecify)	II, Street, Iaci	ary, onice		City or Tox	vn, State)	r nural noute (vulliber,
	spita narai / fillec		29a. Certifier 1 Cartifying Phy	sician: To the best of my	knowledge,	death occurre	d at the time, d	ate and place	, and due to the	cause(s) and manne	er as stated.
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has a completely filled in by the funeral director, page 2.	Medical	(Check only 2 Madical Exami	and manner stated.	ination and	or investigation	on, in my opinio	n, death occu	rred at the time,	date and place, and	due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier			2	9c. License nur	mber		29d. Date signed (M	fonth, Day, Year)
			1////	1/1/						5-3	-06
	5		30. Name and address of person where	ompleted cause of death (tem 23a) (Type, Print)	VI	100	,	2000	2 11 1122
			31. Date filed (Month, Day, Year)	32 Aggietrarie Si	onatide	Saget.	rankl	11	ware	VIIVE	-06 Balto, MD 21231
	Sta Regist		MAY 0 8 2	32. egistrar's Si	15	A CONTRACTOR OF THE PARTY OF TH					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 3, 2006 Physician Anna Ellis 6:30 a /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Lorien Frankford 5 Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) 1942 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 ☐ M 2 🔀 F 218-40-2163 63 Mary Tand Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other treumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6422 Rosemont, Avenue 21206 USA Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (A)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be n Department of Health and Mental I Important: if item 27 ie marked o Walter M. Wilson, Jr. Helen R. Hanneman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Ellis/Son 6422 Rosemont Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) eny injury once. Parkwood Cemeterv 5/6/06 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton Pame and Juras of Facility Teonard J. Nuck. Inc 5305 Har for a koad b Christua of. the Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonale Immediate Cause (Final **Physician** Dr disease or condition resulting in death) /Medical Examiner Obstructive Pulmonary hrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 () pr2120 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an rmea≀ 2 🗷 No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No investigation death 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a Euneral I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Roya Mite Lauvence 501 W. 32. Registrar's Signature State Registrar

			For State Registrar	State of Maryla		rtment of F			Reg.	2000	14363
	Physicia		1. Decedent's Name (First, Middle, Last) SUIDIEV	FU	NAR	1		M	ate of Death Ionth 1AY 0	Day Year 7 2006	3. Time of Death
9	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	or Location of			4c. County of Deal	
	F		5. Social Security Number 6. Sex		LEDICAL s. last birthday)	CENTER If Under 1 Year	BA .	LT/M 4 Hrs. 8, Da	ORE ate of Birth	9 Birt	hplace (State or Foreign
	Funeral Director			M 2X□F 76	Yrs.	Months Days	Hours	Min. May	7, 1929	west	hplace (State or Foreign Junitry) Virginia
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation					10d. Inside City Limits
	e Mary	ctor	Maryland N/A		Baltimor	.e					1 DXYes 2 □ No
	with the	Director	1042 Rodmon Month			10f. Zip Code	1200		10g.	Citizen of What Co	ountry?
	ter death	Funerai	1042 Rodman Way 11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of it Yes, specify Cub	21205 Hispanic Origi	in? (Specify Y	es or No-	U.S.A.	
36	be fled within 72 hours after death with the Maryland Hygiene. All Hygiene and other than "naturel", or items 23s or 28s-f ehow event, it a Medical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Tes, specify Cub		rueno Rican	i, etc.)	Black, Whit	
9500-91212	72 hour		15. Decedent's Educi (Specify only highest grade	ation	16a. Deced	ent's Usual Occup	pation	of working	16b	. Kind of Business	Industry
	within and.	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+) 2 Years	life. C	fice Super	d)	or working	L	Hecht's Co	maan.
א פ	e filed I Hygie other	Be Co	17. Father's Name (First, Middle, Last)	2 10013	COSIT OF	Tice Super		's Name (Firs	t, Middle, Maid		mpany
Maryland	should be filed within nd Mental Hygiene. merked other then umatic event, the M	ToE	Walter Mueller					ve Shoe			
Za	2 6 5 2		19a. Informant's Name/Relationship (Type Debi Buta - Daughter	e, Print)		g Address (Street Park St.		PA 173		ty or Town, State, 2	Zip Code)
ore,	m O L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispos			Date		. Location - City or	Town, State
Baltimore,	permit. Pages Department of Important: If it eny injury or o		4 ☐ Donation 5 ☐ Other (Specify)	0a		emetery Name and Addre		ay 10, 2		timore, Ma	ryland
Ba	Depa Impo eny i		21. Signature of Puredal Service Licensed	"Charles F. Min	er Jr. ²² Le	onard J. F			5 Harford timore, N	i koad Mryland 21	214
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea e cause on each line.	ath. Do not ente	er the mode of dyi	ng, such as ca	ardiac or resp	oiratory arrest,		Approximate Interval Between Onset and Death
N. M.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	BRAIN Due to (or as a conse	E08	EMA			.		5 HOURS
	Examiner		Sequentially list conditions, b.	HEMORI	2 MAGI	C 57	ROK	E			5 HOURS
	nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	SUPR A	, ,	4 PEUTI	C	TN	٥		
0	ficate be executed physician and s the burial-transit	Examin	resulting in death) Last	Due to (or as a conse							
38760,	icate b physic s the bi	dicai	d.								
Box	The law requires that the death certificate has been signed by the attending tage? should be detached for use as	Physician/Me	23b. Was decedent pregnant	ic. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnanc	v			23d. Date of de	
о. П	he dea the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)	<u></u>			Month	Day Year
2	res that t igned by be detac	by Ph	Part II. Other significant conditions cont	inbuting to death but not re	sulting in the ur	nderlying cause gr	ven in Part I.	2	23e. Did tobacc	co use contribute to	the cause of death?
Records,	w require been sig should b	ted						_	1 ☐ Yes		^
Rec	he law e has b ige 2 s	Completed							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?		-		26. Place o	of Death (Che	Yes 2	No To Tes	2 □ No
	Attending Physician: r death. sctor: After this certifice by the funeral director, i	ပ္	1 ☐ Yes 2 No Ho	ospital: Inpatient 20	ER/Outpatien	t 3 DOA Ot			5 Residence	6 □Other (Spe	cify)
0	Attending I death. ctor: After y the funer	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ N			.,,	
Division of	or Attencation death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. L	ocation (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death to the Funerel Director: After th completely filled in by the funeral	aice	29a. Certifier 1X Certifying Physi	ician: To the best of my ki	nowledge, death	occurred at the t	ime, date and	place, and d	ue to the caus	e(s) and manner as	s stated.
	the Hohin 24 the Fu	Medicai	(Check only one) 2 Medical Examination 29b. Signature and title of certifier	er: On the basis of examinand manner stated.		29a Ligan	eo number		:304	Date signed (Mont	h Day Year)
)	Y X F	_	Social distriction of the state			REC	-00	O	n	1AY D	6.2006
	10		30. Name and address of person who con	npleted cause of death (It	em 23a) (Type, I	Print)				n- BA	5,2006 TIMOKE, HO
	Sta	to-	JR. LIPIKA 31. Date filed (Month, Day, Year)	SAMAL Registrar's Sign	794 pature	DEA	STER	N A	VEN	JE VA	-1170NE,MO 2127
	Registr		MAY 0 8 2006	Marie &	F BOOK	1					

		1	For State Registrar	State	of Ma	aryland		artment of H tificate of L		and M	lental F		ene, () (06	14364
			Decedent's Name (First, Middle	le, Last)							2. Date of Month	Death	Day	Year	3. Time of Death
Physi	iciar dica		Evelvn	Mar	ie			Grah1			May 3	3. 2	2006	1001	11:20 p M
Exan			4a. Facility Name (If not institution					4b. City, Town, or	Location o	of Death			4c. County	of Death	
			Mount Claire A	ssisted	Livi	ng		Fulton					Howar	cd	
Funera	al	:	5. Social Security Number	6. Sex 1 ☐ M 21X F			ast birthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of (Month,	Day, Y		9. Birth	place (State or Foreign intry)
Directo	or		217-32-8751	10 M 201F		90	Yrs.				June	11,	1915	Mar	yland
and *		⊢	Usual Residence of Decedent 10a. State 10b. County	,		10c. City	, Town or Lo	cation							10d. Inside City Limits
faryla sho	1														1 TayYes 2 □ No
be filed within 72 hours after death with the Maryland and Hygiene. I have then "natural" or items 23a or 28a-1 show avent, the Madical Exercitive mast be notified at	Director	1	Maryland N/A 10e. Street and Number			Ba.	Ltimor	10f. Zip Code				100	. Citizen of	What Cou	intry?
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eath	Farnarai	5	11. Marital Status	12. Was De	ecedent	Ever in U.	S. 13. V	Was Decedent of Hi	ispanic Orig	gin? (Spe	ecify Yes or	No-		ce - Ameri	ican Indian,
fter d	2	5	1 Never Married 2 Mar	Amed	Forces?		'	f Yes, specify Cuba	n, Mexican	, Puerto	Rican, etc.)		-	ck, White	_
urs al	1	2	3 ☐Widowed 4 ☐ Divorced					¹⊡Yes 2. No	Specify:				Specif	y: Wh	ite
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yland 212 buld be filed withi Mental Hygiene. arked other than	ļ	2	William	С.			Smitl	n	Gra	ce		Ε.		E	llis
E SEE	1		19a. Informant's Name/Relations					ng Address (Street a							p Code)
and 2 and 2 ealth a n 27 is			Beverly A. Hoff	man (Dau	ghte	r)	3644	Hineline	Road	, Ba	ltimo	re,	MD 21	1229	
S S S S S S S S S S S S S S S S S S S			20a. Method of Disposition	a	- 64-4-	20b. P	lace of Dispo	sition (Name of natory or other plac	е)	C	ate	20	c. Location	- City or T	own, State
Pages nent of thint: If it			1 反 Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		m State		-	ark Cemet		lay 8	, 200	6 B	altimo	re,	Maryland
그 트랜글	8		21. Signature of Funeral Service	Licensee	and the second s	physical devices the same of the s	22	. Name and Addres	ss of Facilit	y Lo	udon	Par	k Fune	ral	Home
	OUC.						3	620 Wilke	ns Av	e.,	Balti	mor	e, MD	2122	9
A _{se}			234 Part Enter the disease, o shock, or heart failure. Lis				n. Do not ent	er the mode of dyin	g, such as	cardiac c	or respirator	y arres	st,		Approximate Interval Between
Physicia	in l		Immediate Cause (Final	PV	A .		o rei	nal dis	Onc	0					Onset and Death
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cuted	- Animore		that initiated events) c											
an ar			resulting in death) Last	Due	to (or as	a consequ	uence of):								
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial transit	loop	2		d											
od rtifica pp as th	100	2	IF FEMALE.												
wrequires that the death certifical been signed by the attending phashould be detached for use as the	1	ritysiciatume	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, 1□Liv		of pregna		Ectopic pregnancy						ate of deliv	•
deatl	100	2	in the past 12 months?		egnant at	time of de		Other (specify)				_	Mi	onth	Day Year
by the	, i		9 Unknown	3001	IN IOWIT										
s that		, C	Part II. Other significant conditi	ions contributing to	death b	ut not resu	ulting in the u	nderlying cause give	en in Part I	•					the causa of death?
aquire en si											1	Yes	2 No	3 🗌 Pro	bably 4 Unknown
law requires las been signed 2 should be	3	completed									24a. V	has an utopsy	24b.	Were aut	opsy findings available ompletion of cause of
The The Ite ha	1	E									1 U Y	erform		death?	
icien: T sertificat ector, pa		U	25. Was case referred to medica	al					26. Place	of Death	(Check of		-		
ysici ysici is ce direc		0	examiner? 1 ☐ Yes (XNo	Hospital:	☐ Inpatie	ent 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nu	ırsing Ho	me 5 🗆 F	tesiden	ce 6 Oth	her (Spec	in Assisted Living
g Phy g Phy er this	1		27. Manner of Death	/4.4	ite of Inju	ry v Year)	28b. Time o	28c. Injun Worl	y at		28d. Descr	be how	injury occur	rred	U
Attending at death. ector: Afte by the fune	1	2	Natural 5 Pendi 2 Accident invest	igation	,	, ,	,,		Yes 2	No					
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s afte	1	Sel			many, or	o. (opcon)	,,								
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director, The this certificate has completely filled in by the funeral director, page 2								h occurred at the tin							
n 24 he Fu		edical	one) 2 Medica		e basis o lanner st		oon and/or in	vestigation, in my 0	рипон, ама		ou at the III				
To the To the Comp		٤	29b. Signature and title of certific	er / 0	/		. 1	29c. Licens	e number	1 - 4		290	d. Date signe	ed (Month	, Day, Year)
			▶ MMd	MIL	1)1	1	WIL	DE	057	-13(Q		5/4	1/06	
\	0		30. Name and address of person	who completed c	ause of c	leath (Item			_	111.		\ I	101-1	MI	0114.0
1	U		Kisa Huber	-, md		140	Bi	(minah	am	Wa	40	JW	STOCK	-1111	01165
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Regi	istra	r	8 D YAM	2006	1 190	U /	17								

			1 - For State Registrar	State of Maryla		rtment of H tificate of L			ene 006	14365
	Physici	an	Decedent's Name (First, Middle, Last)	John W.	Crammo	r		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give si		Gramme		Location of Death	05	02 200 4c. County of Dea	
	Examin	er	Franklin Sauce	ure Hospit	al	Rossv	ille		Bal	timore Co.
	Funeral Director		5. Social Security Number 6. Sex 1212-32-4327	7. Age (În yrs 71	: last birthday) _ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 5,]	9. Bir 934 N	thplace (State or Foreign ountry) ew York
	ס		Usual Residence of Decedent					June 572		
\leq	anylar how	پ	10a. State 10b. County		ity, Town or Loc		Middle Ri	TTO Y		10d. Inside City Limits 1 Tyes 2X No
_	death with the Maryland ims 23s or 28s-1 show ir must be notified at	Director	Maryland Balt 10e. Street and Number	imore		10f. Zip Code	MIGGIE KI		0.0000000000000000000000000000000000000	
=	with the party of	2		7.		212	20		g. Citizen of Whal C Inited Sta	
John	ne 23	era	7518 Biscayne Bay	2. Was Decedent Ever in I	U.S. 13. V		spanic Origin? (Spe n, Mexican, Puerto		14. Race - Am	erican Indian,
Do	2 hours after death with the Marylan eturel', or items 23s or 28s-f ehow ical Examinar must be netitied at	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2√ No If Yes, Give		Yes, specify Cuba ☐ Yes 2√☐ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc.
7.8 8.0 8.0 8.0 8.0 8.0 8.0 8.0 8.0 8.0 8	72 hours after neturel', or its dical Exemina	d b	37☐ Widowed 4 ☐ Divorced	Year or Dates:						White
₹.	N E W	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	ent's Usual Occupa kind of work done o OO NOT use retired	luring most of worki	ng 1	6b. Kind of Business	/Industry
77	d within piene. r then "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Fo	oreman			Steel I	ndustry
₹ 2	be filed tal Hygid d other event,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	laiden Sumame)	
170 ylan	should be ind Mental is marked of umatic eve	2	Oliver Grammer					lna Garne		
Maryl	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Typ	3		•	e Bay Blv		City or Town, State,	
_	es 1 and 2 should b of Health and Ment fitem 27 is marked ir other treumatic e		Jacqueline Gramme 20a. Method of Disposition			sition (Name of natory or other place		-	Oc. Location - City or	
JO II	Pages nent of I int: if it		1 Burial 2 □ Cremation 3 □ Re Donation 5 □ Other (Specify)	moval nom State		natory or other place 11 Mem. G	1	2006	Middle F	iver, MD
Baltimore	permit. Page Department of Important: If any injury or ance.		21. Significe of Funeral Service License		22 22	Name and Addres	s of Facility Funeral	Home of	Dundalk,	Inc.
	707 a a		23a. Part1 Enter the disease, or complic	·	Do not onto		e Ave. D			21222 Approximate
		-	shock, or heart failure. List only one	cause on each line.	olo Kali	ar the mode or dying	, sucii as caidiac c	i respiratory arre	51,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	CY 10CK	/				3 days
	Examiner		h and the second	SPPSIS	400.000 0.7.					
	₽ ≒	ner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	iduanga of):					
	ecute end I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conse	duence of):					
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687		edical	0.							
Вох	eath certific attending pl I for use as t	an/M	230. was decedent pregnant	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of de	
О. В	he dea the att	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
, P.O.	that the	y Ph	Part II. Other significant conditions conf	ributing to death but not re	sulting in the un	iderlying cause give	n in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rds	quires an sign uld be	q pa	PANCREATIC	CANCER	WITH .	LIVER A	ETASTASIS	1 Yes	s 2□No 3□P	robabiy 4 Unknown
) ၁	lawre as bee	Completed						24a. Was an	24b. Were a	ulopsy findings available completion of cause of
=	. The cate h	Con						perform	ed? death?	2 □ No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		2 DOA Othe	26. Place of Death			
of	Phys r this ral dii	7.	1 ☐ Yes 2 ☑ No '" 27. Manper of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury Work	4 Indianily 110	me 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
lon	nding th: :: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		? /es 2 \(\text{No} \)			
Division of Vital Records,	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R	ural Route Number.
۵	ital or irs aft rel Di									
	To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my of	e, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License		29	d. Date signed (Mon	th, Day, Year)
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		1	1 - State of Maryla		artment of H			ne 2.006	14366			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MARY L HUS	TER			2. Date of Death Month	Day Jear	3. Time of Death			
	Examir		4a. Facility Name (If not institution, give street and number) KRISLEIGH ASSISTED LIVING 5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday)	4b. City, Town, or SEVERNA If Under 1 Year		8. Date of Birth	4c. County of Death	UNDEL			
	Funeral Director		215.09.8542 Usual Residence of Decedent	Vrc	Months Days	Hours Min.	Month, Day, Y		place (State or Foreign Intry) RELAND			
	the Maryland 28a-f show cotified at	tor		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	or 28	Funerai Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	intry?			
	eath w	erai	831 RITHCIE HWY 11. Marital Status 12. Was Decedent Ever in	118 12	21146 Was Decedent of His	enania Origin? (Sar	noify Voc or No	USA 14. Race - Amer	ican Indian			
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other treumatic event, the Mudical Examinational by notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give Year or Dates:		If Yes, specify Cubar	Specify:	Rican, etc.)	Black, White				
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Maryland	2 should be filed withir and Mental Hygiene. Is markad other than eumatic evant, the M	To Be	ANDREW TURNBULL	10h Maili	and Address (Street	MARY	I Boute them bes C	Shara Taura Chata 7	in Carda)			
Ma	and 2 sh lealth and m 27 is n her treun		19a. Informant's Name/Relationship (Type, Print) BARBARA J. WITOWSKI DAUGHTI					tity or Town, State, Zi				
nore,	0 0	1 1	1 varial 2 ☐ Cremation 3 ☐ Removal from State	-	matory or other place	9)		c. Location - City or T				
Baltimore	permit. Pag Department Importent: I any injury o		21. Signalure of Funeral Service Litens e		EN CEMETER 2. Name and Addres LNK FUNERA			CLEN BURNI	E, MD			
			X GREGORY F.NK MOI 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.					E, MD 2106	Approximate			
	Pnysician /Medical		shock, at heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Aul	heart	fail	uu		Interval Between Onset and Death			
g.	Examiner	ja l	Sequentially list conditions, b. Due to (or as a core	Hyp.	eten	rion			year			
,	ate be executed hysicien and the burial-transit	Examiner	if any, leading to unit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consider the cause of the caus	equence of):					V			
8760	ate the	dicai	d									
O. Box 6	The law requires that the death certifics ate has been signed by the attending phoage 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 2 Fe	etal death 3	⊒Ectopic pregnancy] Other <i>(specify)</i>			23d. Date of deliv Month	rery Day Year			
ds, P.	uires that signed b d be deta	þ	Part II. Other significant conditions contributing to death but not re	ssulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	12			
Records,	w requir been si should	iete	Pantage tre (1	218	1 ilan	20	24a. Was an	24b. Were aut	opsy findings available			
Re	The lav ate has page 2	Completed	astronosi	0)	o part		autopsy performe	d? prior to co death? INo 1 □ Yes	opsy findings available ompletion of cause of			
Vital	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				(Check only one)	1<1	115 - LE 16H			
The state of the s												
	To the Comp	N	29b. Signature and title of certifier The Charles The C	Man	29c. License	2143	8 /	Date signed (Month) NAY 03	Day, Year) 2006			
1	ē .		30. Name and address of person who completed cause of death (It	ет 23a) (Туре, У У	Print) DEFL	ENSE !	HAHW	Ay Ann	APOLIS M DZI4U,			
	Sta Regist		31. Date filed (Month Pay Year) 32. registrar's Sig	nature	asoli							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day 4, 2006 Physician William C. Horsey MAY 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson Months Days Hours Min. Sept. 7, 1921 5. Social Security Number 6. Sex 1 M 2 F 9. Birthplace (State or Foreign Mary) and 7. Age (In yrs. last birthday) **Funeral** 215-14-9770 84 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show th and Mental Hygiene. 27 is marked other then "naturel", or freme 23a or 28e-1 shov treumatic event, the Modical Examirer must be multified at Director Towson 1 Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 1636 Alston Rd. USA Funeral Pages 1 end 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth McGeeney William C. Horsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Depertment of Health ar
important: if item 27 ie
eny injury or other treu Mrs. Dorothea Horsey/ Wife 1636 Alston Rd. Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 5-9-06 Timonium, Md. Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fugeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CACHEXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ed by the ettending physicien and detached for use es the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed FAILURE TO THRIVE Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No cate has been sig., page 2 should b 3 ☐ Probably 4 ☐ Unknown DEMENTIA 1 ☐ Yes Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 21 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient this Certification: To 1 ☐ Yes 2 🗙 No 2 ER/Outpatient 3 DOA Vithin 24 hours after death.

To the Funeral Director: After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) D56@3@ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 31. Date liled (Month, Day, Year) 32. Segistrar's Signature 7601 OSLER DRIVE TOWSON, MARYLAND 21204 State Registrar MAY 0 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:55 P M Ruth Lorraine Hans May 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Co. Catonsville 756 Charing Cross Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 및 F Months Days Hours Yrs. 73 Director Feb. 9,1933 Massachusetts 219-28-3018 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location Moye 10a. State 10b. County or than "natural", or itema 23a or 28a-f ehov the Madical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Baltimore Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 756 Charing Cross Road 21229 United States death Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hygiene.
ant: if Item 27 is marked other then "natural", or Ite ury or other treumatic event, the Madical Examins 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 1 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care Provider 3 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jessie M. MacLellan 2 Harold G. MacKinnon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 2811 McComas Ave. Mrs. Eva Malozi (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State vartment or vortant: f 4 Donation 5 Other (Specify) Service Corp. 5/5/2006 Towson, Maryland 21. Signature of Funeral Jervice Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Arterioscleratio 10 years **Physician** Cardiovasci /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 No Day 5 Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should I ieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl Compl autopsy performed 20 No 1 Yes 1 Yes 2√2 No the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be miner' Other: 1 Yes 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Accident 5 Pending investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

within 24

Mil: 31. Date filed 'Month, Day, Year) 8 2006 MAY 0

29b. Signature and title of certifier

HELL MO

6 32 Registrar's Signature

tucis

30. Name and address of person who completed cause death (from 23a) (Type, Print)

Trimble

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 1, 2006 Physician A^{M} Robert Montgomery Johnston, II 9:11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 2, 1945 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1X M 2 T F Indiana 61 Yrs. 266-74-9388 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 X No Bethesda Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5402 Glenwood Road 20817 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No
If Yes. Give
Year or Dates: Vietnam 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Builder permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ie marked othneny injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Adeline Clouser Robert Montgomery Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5402 Glenwood Road, Bethesda, Maryland 20817 Lynda G. Bush/Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition May 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland 2006 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase, Inc. 21. Signature of Funeral Service Licensee M00198 7557 wisconsin Ave., Bethesda, MD 20814-3501 Part 1. Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 500515 /Medical Due to (or as a consequence of): Examiner Leukinic Crisis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myclogeness Leutenia Chronil Due to (or as a consequence of). Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 □Uπknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate hes tirector, page 2 s 25 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: Natural 5 Pending 1 Yes 2 No death. investigation within 24 hours after death.

To the Funeral Director: completely filled in by the fi 2 Accident illed in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3011 056652 May 2, 2006 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pottersth MD Medical center Drive, Lockvilly MO 9901 MAXYYW 32 Registrar's Signature 31. Date filed (Month, Day, Year) Secret J State MAY 0 8 2006 Registrar

06-02993 Ervin Kampe Please Type or Print in Black Indelible Ink
Amend Themson Department of Health and Mental Hygiene

лп катре		Registrar	ertificate of Dea		R	eg No. OOO	11076
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last) Ervin Kampe			2. Date of Dea Month May 3, 20	Day Year	3. Time of Death / 0909 hrs
		4a. Facility Name (if not institution, give street and number) 407 Ross Drive		, Town, or Location of esville	f Death	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 111 M 2 F 63	last birthday) If Ur Yrs.	nder 1 Year If Under https://dee.com/deers/deeps/dee	24Hrs. 8. Date of Bir 07-06	Foreig	thplace (State or gn untry) Latvia
v any			y, Town or Location				10d Inside City Limits
aryland 8a-f shov at once.	Director	10e. Street and Number	dersburg	Zip Code	1	0g. Citizen of What Cou	1 Yes 2 X No
th the M. 23a or 2 notified		407 Ross Drive		21784	in 2 / Smarifu Van ar Na	USA	ican Indian, 8lack
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiew in matural", or items 23a or 28a-f show any important. If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Novorced or Pates: 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No No Novorced or Pates:	If Yes, spe	cent of Hispanic Original Cuban, Mexican, $2 \overline{X} $ No specify:	in? (Specify Yes or No Puerto Rican, etc.)	White, etc	ite
2 hours a "natura	eted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		vorking life. DO NOT	use retired)	16b. Kind of Business/	
-0036 I within 7 giene iher than	Completed	+2	servio		ain traine:		e industry
1215. d be filed lental Hy arked of	o Be C	Janis Kampe	10h Mailing Addre	Frie	da (maiden	name unkno	
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene in 27 is marked other than numatic event, the Medica	Ţ	19a. Informant's Name/Relationship (Type, Print) Steven Kampe (son)	5455 E.	Empire, B	enton Harb	or, MI 4902	2
Baltimore, permit. Pages I an Department of Hea Important: If ite			Place of Disposition (No crematory or other place) Note: 1 vary Cemet		Date 5-10-06	20c. Location - City or Benton Har	
Baltir permit. F Departme Importation		21. Signature of Funeral Service Licensee Fruer Staught Stubblet			Haight Furykesville,	neral Home o Md 21784	& Chapel
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ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	of):				
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At	home, farm, street, facto	ory, office building, etc	c. 28f. Location (or Town, \$	Street and Number or Ru State)	ural Route Number, City
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowled one) 2 Medical Examiner: On the basis of examination					
To with To com	Med	29b. Signature and title of certifier		29c. License number		29d. Date signed (Md	onth, Day, Year)
		30. Name and address of person who completed cause of death (Ite	em 23a)	O.C.M.E.		May 4, 2006	
7		Susan Hogan MD. Assistant Medical Examine	er 111 Penn Str	eet, Baltimore, N	/ID 21201		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signa MAY 0 8 2006	A Sound	9			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:16 AM Audrey May Lambert 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT AGNES BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 05-22-1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Months Barto, MD 1 □ M 2X F 219-30-0492 72 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2227 Ashton St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status WHITE White, etc. 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fiin Department of Health and Mental Hy importent: if Item 27 is marked otheny eny injury or other traumatic event Be Anna Smith Raymond Ensey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3227 Kessler Rd. Lansdowne MD 21227 19a. Informant's Name/Relationship (Type, Print) Michael D. Lambert Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Loufdon Parky Cemetery N□ Buriai 2 □ Cremation 3 □ Removal from State kens Ave. 04-05-06 Baltimore Mary
22. Name and Address of Facility Loudon Park Funeral Home
3620 Wilkens Avenue
3620 Wilkens Avenue
3620 Wilkens Avenue 4 Donation 5 Sther (Specify) Baltimore Maryland 3620 Wilkens Ave. gnatur of Populal Service Signature Baltimore, Mary land Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Imm ate Cause (Final dise or condition resulting in death) JOY 2004 ANCER Physician /Medical Due to (or as a consequence of) Examiner HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit MAR 2006 IVER Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 DNo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been signe funeral director, page 2 should be OVER EXTREMITY DEEP VENOUN 1 Yes 2 No 3 Probably 4 Unknown THIZOMBOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **D**No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 1 Tes 2 TNo 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 31. Date filed (Month, Day, Year)
MAY 0 8 2006

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVE 32. Registrar's Signature

ORIGINAL

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

MAY, 03, 2006

			State of Maryland / Department of Certificate of Pagistrar			giene 0 0 6	14372
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Yea	
	/Medic		Walter A. Link		May	4, 2006	4:38 A ^M
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	调带	W	**************************************	Registrar 1. Decedent's Name (First, Middle, Last)		00	Tuncate of	Dealii	2. Date of De	Reg. No. O	3. Time of	Death
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	E _{kg}	Funeral Director		5. Social Security Number 6. Sex 7. A 1 M 2 F 7. A	ge (In yrs. 1	ast birthday, Yrs.			8. Date of Bir (Month, Da Aug. 29	th y, Year) 9, 1943	Birthplace (State or Country) Maryland	r Foreign
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	Divis	l or Atten after deati Director: I in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Ir building, e	ijury - At ho tc. <i>(Specif</i> y	me, farm, st	reet, factory, office		28f. Location (City or Tou	Street and Number vn, State)	or Rural Route Numb)9 <i>r</i> ,
92%		To the Hospital or At within 24 hours after o To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner sand mann	of examinat	wledge, deat ion and/or in	th occurred at the tin	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. due to the cause(s)	AT HE LOS
0		To the within 2 To the complet	Me	29b. Signature and tyle of certifier	7		29c. Licens	se number		29d. Date signed (/	Month, Day, Year)	
				I foron /Stal	2		20	06/19	9	May.	6,2006	5
	}	5+1		30. Name and address of person who completed cause of	death (Item	23а) (Туре,	Print) 6601	N. CHAR	LES ST	REET		
		Sta Registř			rar's Signat	ure	Angello 8	-3014				
			4			84 F	North Bar					

		ı	1 - For State Registrer	State of Ma	aryland		artmen rtificat			and M		iene og. No.	06	143	74	
	Physici	an	1. Decedent's Name (First, Middle, Las Margaret Wheeloc	•	n						2. Date of Dea Month	Day	2006	3. Time of		
7	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number)		er	4b. City,	Town, or	Location o	of Death			unty of Death			
	Funeral Director		5. Social Security Number 219-22-5126 1 Usual Residence of Decedent	ex y 7. Ag	e (In yrs. Ias 79	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Dec. 8,	1926	9. Birth Con Mar	pplace (State of unity) y land	or Foreign	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show sary figury or other traumatic avant, the Madical Examinar must be notified at ance.	I Director	10a. State 10b. County MD Baltimor 10e. Street and Number 8623 Tower Bridge	, ,		Town or Lo ervil					1	0g. Citizen USA	of What Co	10d. Inside Ci 1 ☐ Yes untry?	•	
9003	nours after deat ursi', or items 2 il Exeminer mu	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 1 If Yes, Give Year or Dates:	No	,	1 □ Yes :	2 X vo	Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Sp		nite		
Maryland 21215-0036	ed within 72 l ygiene. Ier than "nat t, the Madica	Complete	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	(+)	16a. Deced (Give life. L Homema	kind of wor DO NOT us	al Occupa rk done d se retired,	luring mosi)			Own H		ndustry		
yland	iould be fill I Mental Hy varked oth	To Be	17. Father's Name (First, Middle, Last) Carl Wheelock						Marga	ret	(First, Middle, Wilson					
re, Maı	t and 2 st Health and tsm 27 is n other traun		19a. Informant's Name/Relationship (19a Gail L. Winn / 20a. Method of Disposition	daughter	20b. Plac	5006 (Grave	Run	Road	i; Mi		MD 21				
Baltimore,	Pages tment of tant: If I	1 \(\tilde{\Omega} \) Burial 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) Removal from State 4 \(\tilde{\Omega} \) Donation 5 \(\tilde{\Omega} \) Other (Specify) \(\tilde{\Omega} \) Druid Ridge Cemetery 5/9/06 Pikesville,														
Ba	Depar Depar Impor eny In		21. Signature of Property Salvan Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 212													
,	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. LEFT V	ENTR	ICUL				cardiac c	or respiratory arr			Approximate Interval Bette Onset and I	e ween Death	
	Examiner			Due to (or as CARDIC			DCK							1 HOU	R	
8760, 🚁	cate be executed physicien end i the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SEVERE Due to (or as	MIT	RAL	REGU	RGIT	ratio	NC				20 YE	ARS_	
P.O. Box 68	The law requires thet the death certific ste hes been signed by the ettending pl sege 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pr					23d.	Date of delin		/ear	
	w requires thet been signed b should be deta	Ď	Part II. Other significant conditions c	ontributing to death b	ut not resultin	ng in the ur	nderlying c	ause give	n in Part I.		23e. Did tol	1		the cause of do		
Division of Vital Records,		Completed									24a. Was a autops perform	y	4b. Were aut prior to c death? 1 \(\sum \text{Yes}\)	opsy findings a completion of ca 2 \(\text{No} \)	available ause of	
<u> </u>	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🖔 Inpatie	nt 2 EP	VOutpatien	t 3 🗆 DO	A Othe	NP"		n <i>(Check</i> on <i>ly on</i> me 5 ☐ Reside		Other (Spec	ifv)		
o uoi	Attending Physician: r death. sctor: After this certifice by the funeral director.		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	ry 28	3b. Time of Injury	M 2	8c. Injury Work		- 1	28d. Describe ho					
Divis	2 th 2 in	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, stre	et, factory	, office			28f. Location (St City or Town		umber or Ru	ral Route Num	ber,	
	To the Hospitel within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exem	ysicien: To the best of niner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred estigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the ca ed at the time, d	ause(s) and ate and pla	manner as ce, and due	stated. to the cause(s)	
	To the within To the complex	Me	29b. Signature and title of certifie	12			290	License	number		2	9d. Date si	gned (Month	Day, Year)	,	
	-		30 Name at address of name (1)	completed was	eath /ltem 01	3a) (Tues 1		D 49	3372		/	VIAY	4,2	2006	7	
	10		30. Name a address of persoy of a JOHN C. LASCHI	100		3a) (1ype, 1 76 Ø 1	•	ER I	ORIVE	Ξ, Τ	OWSON,	MAR	YLANI	2120	4	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 20		ar's Signatur	· An	will.									

			For State Registrar	State of Maryland		nent of He		ental Hygie	211116	14375
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	,			2	2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution give :	al 22 South Gr	eene St	City, Town, or Li Ra Hime Inder 1 Year	re	2000	4c. County of Dea	
	Funeral Director		5. Social Security Number 510.52.1075 Usual Residence of Decedent	7. Age (In yrs. last			Hours Min.	B. Date of Birth (Month, Day, Ye DEC 14,	9. Bir 1932	thplace (State or Foreign buntry) MS
	Maryland f show	or	10a. State 10b. County		own or Location	n				10d. Inside City Limits 1 Yes 2 No
	or 28s	Direct	DE KENT 10e. Street and Number		DOVER 10	of. Zip Code		10g.	. Citizen of What Co	Duntry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or iteme 23a or 28a-f show event, the Medical Event or must be notified at	by Funeral Director	1443 EAST DENNY'S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	RD 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 XX Yes, Give XX Year or Dates:			1 anic Origin? (Spec Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	USA 14. Race - Ame Black, White	te, etc.
21215-0036	within 72 hou ene. then "nature	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 1 e campleted) College (1-4or 5+)	lite. DO N	Usual Occupation work done dur OT use retired)	on ing most of working	7	o. Kind of Business	,
	e filed v Il Hygie other t	Be Co	12 17. Father's Name (First, Middle, Last)		TEACI	HERS AID	E 8. Mother's Name (First, Middle, Mai	EDUCATI den Sumame)	ON
Maryland	should be nd Mental marked c	70	HORACE COLLIER 19a. Informant's Name/Relationship (Ty	na Print)	10h Mailing Ad		NANNIE MA		NY ity or Town, State,	7in Codol
	and 2 sl valth an 27 is r er traur		BARBARA HOLMAN	DAUGHTER			Y'S RD DO			21p C00e)
Baltimore,	permit Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 13 Burial 2 □ Cremation 3 □ The Company of the Compa	emoval from State	e of Disposition etery, cremator IARE VET	y or other place)	5.10.2		EAR DE	Town, State
Balt	permit Pag Department Important: It any injury o		21. Signatur Truneral Service Licens K. GREGORY K.W.	M01148	FINE 426	CRAIN H	L HOME, F WY SW GLE	A. IN BURNII	E. MD 210	61
1760,	by Course as the burial-transit	ılcai Examiner	23a. Part1 Enter the disease) or omn shock or heart failure. List only limediate Cause (Final disease) or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or niqury that intitated events resulting in death) Last	Due to (or as a consequent). Due to (or as a consequent).	ce of): ractur ce of):	e	such as cardiac or	ass	SAC.	Approximate Interval Between Onset and Death
P.O. Box 68	D 0 D	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 □Ecto	pic pregnancy er (specify)			23d. Date of de Month	livery Day Year
	The law requires that the de- ate has been signed by the a page 2 should be detached fo	þ	Part II. Other significant conditions con	ntributing to death but not resultin	g in the underly	ring cause given	in Part I.	23e. Did tobac	21	o the cause of death? robably 4 □Unknown
Division of Vital Records,		Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 \square No
F Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ⊠Inpatient 2 □ ER	/Outpatient 3[Othor	6. Place of Death (e 6 Other (Spe	cify)
ion o	To the Hospital or Attending Physician: which 24 hours after deals To the Funeral Director. After this certific completely filled in by the funeral director.		27. Manner of Death 1 □Natural 5 □ Pending 2 ⋈ Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury a Work? 1 1 Ye		Id. Describe how		
Divis	s after de s after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fa	Roc. J	2	Sf. Location (Stree City or Town, S	t and Number or R state)	ural Route Number,
	About 24 hour Funer etely fills	edical	29a. Certifier 1 Certifying Physical Control Check only one) 2 Medical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occi and/or investig	urred at the time, ation, in my opin	date and place, an ion, death occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	s stated. s to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	7 N	10	29c. License n	umber	29d.	Date signed (Mont	,
0	L		30. Name and address of person who co			C1	Be Hanore	mall	31701	006
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 20	32. Registrar's Signature		W		July		

		-	For State Registrar	State of Ma		epartmei <i>Certifica</i>				lental Hy	giene Reg. No	006	14376
	Physicia /Medic	an al	Decedent's Name (First, Middle, Last) Steven C 4a. Facility Name (If not institution, give seconds)		11	4b. City	, Town, or	r Location	of Death	2. Date of De Month May	6,	Year 2006 ounty of Death	3. Time of Death 5:59am M
	Examin Funeral Director		15936 Meadow Walk 5. Social Security Number 6. Sec	Road	(In yrs. last birth	nday) If Under	r 1 Year	dbine If Under Hours		8. Date of Bir Month, Da Mar .		Howard	lace (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County MD Howa	rd	10c. City, Town	or Location Woodbi	ne						0d. Inside City Limits 1 ☐ Yes 2√ No
	e 23a or 28e	eral Director	10e. Street and Number 15936 Meadow Wal	k Road	wer in II S			21797	igin? (Spe	acify Yes or N	US	A Race - Americ	
9600	nours after de urel', or item il Exerciteer i	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes	X No	Specify:		ecify Yes or No Rican, etc.)	S	Black, White,	ite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland at Hydison. All the Willen "retural", or items 23s or 28s-f show other then "retural", or items 23s or 28s-f show event, the Madical Examinant most be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		-)	Decedent's Us (Give kind of w life. DO NOT Presid	ork done d ise retired	during mos			Secur		vice Co.
ryland	should be file of Mental Hy marked oth matic event	To Be (17. Father's Name (First, Middle, Last) F. Curtis Mar 19a. Informant's Name/Relationship (Ty		19b.	Mailing Addres	s (Street	1	M. Sh	o (First, Middle nirley M Route Numb	Stever		Code)
nore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mentle Hydiene. Important: If item 27 is marked other then "neturel; or iteme 23a or 28e-f ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.	(-	Mrs. Teresa Marsha 20a. Method of Disposition 1 Burial 2 Occemution 3 DF		20b. Place of cemeter,	Disposition (Na., crematory or	me of other plac	(e)	C	Date	20c. Loca	21797 tion - City or To	
Baltimore,	permit. P. Departme Important eny injury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens			-						A. (Bo:	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	the death. Do note.	Mai							Approximate Interval Between Onset and Death
8760,	icate be executed physicien and s the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):							
P.O. Box 68	death certif e attending ad for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1⊟Live birth 24⊟ Pregnant at 9⊟ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (1			236	d. Date of delive Month	ery Day Year
rds, P.	The law requires that the see has been signed by th page 2 should be detache		Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the underlying	cause giv	en in Part	l.		tobacco use	1	ne cause of death?
al Reco	The lay	e Completed	25. Was case referred to medical					26 Place	o of Dooth	24a. Was auto perf 1 Yes	opsy ormed? 2/2 No	24b. Were auto prior to co death? 1 Yes	psy findings available impletion of cause of 2 RNo
Division of Vital Records,	Phys this aldi	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	28a. Date of Injur (Month, Day	Year) In	ime of	28c. Injur	ier: 4□N	ursing Ho	-	idence 6[Other (Specif	y)
Division	To the Hoepitel or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At home, far						(Street and I own, State)	Number or Rura	al Route Number,
	To the Hoepitel of within 24 hours elected to the Funeral completely filled it.	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and	d/or investigation	n, in my c	me, date a opinion, de se number	nd place, ath occurr	and due to the red at the time	, date and p	nd manner as s lace, and due to signed (Month,	o the cause(s)
	120		1 1/m	ompleted cause of de	eath (Item 23a) (Type, Print)	000	1678	-6		_	10/0	1
1.0	Sta Regist		30. Name and address of person who control of the state o	32 Registra	r's Signature	foods	120	#/	6 0	luthe	eulle	ME	21093

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Division of Vital Records, P.O.

signed by the a d be detached f

page 2 should

has

certificate : After this certifical funeral director, I

within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

Attending Physician:

Hospitel or

δ

Be Completed

Certification: To

Medical

Physician

/Medical

Examiner

10a, State

Director

Be Completed by Funeral

2

MD

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

99

to Heath and Mental Hygiene.
If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be Department of Health and Mental Importent: if item 27 is marked 1 any injury or other treumatic events.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner burial-transit attending physician for use as the buria

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed 1 🗌 Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

4 - Homicide

29a. Certifier

25205

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers BMC 6701

N. Chales & Balto, Md Z. 20x

State Registrar

31. Date filed (Month, Day, Year) MAY 0 8 2006 32 Registrar's Signature

			1 - For State Registrar		State		nd / Dep		nt of H	lealth	and M	•		200	5	143	78
	Phys	ician	Decedent's Nam		ast)							2. Date of D Month	Da		ear	3. Time of	
	/Me	dical	Sylvia H		in street and ou	mbar)		4h Cih	Tour	Location		May	5	20 . County of		7:20	AM
V	Exar	niner	Stella M		ve street and nu	imber)			nium		or Death		i	altim			
	Funer	al	5. Social Security N	lumber 6.	Sex	7. Age (In yrs	s. last birthday,	If Unde	r 1 Year	If Under	r 24 Hrs.	8. Date of Bi	inth		. Birth	place (State o	r Foreign
	Direct		217-60-3	362	1□ M 2□XF	91	Yrs.	Months	Days	Hours	Min.	Nov. 8	ау, Үөаг • 19	14	Cou	yland	
	P .		Usual Residence of	T		10- 0	N. T.										
	anyla	7	10a. State	10b. County			City, Town or L	ocation								10d. Inside Ci 1 ☐ Yes	
	the M	ecto	MD 10e. Street and Nu	Baltimo	re	lov	vson	10f. Zip	Codo				10a Ci	tizen of Wh	at Cour		X
	with	흐	619 Hill					212					USA	uzen or vvn	at Cou	ntry ?	
	17713-6036 within 72 hours after death with the Maryland ene. then "netural", or iteme 23e or 28e-f ehow then hatters!	Completed by Funeral Director	11. Marital Status	CII NOGG	12. Was Dec	edent Ever in	U.S. 13.			ispanic Or	rigin? (Spe	ecify Yes or N Rican, etc.)		14. Race -	Ameri	can Indian,	
	or ite	골		ried 2 Married	Armed F	orces? 2∐XNo						Rican, etc.)		Black,			
. 8	ours a	l by	3 Widowed	4 Divorced	Year or I	ove Dates:	E2	1 🗆 Yes	21 A No	Specify	:			Specify:	WII	ıte	
a B	21215-0036 Id within 72 hours aft giene. or then "natural", or , the Medical Exami	ete	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)	•	16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa	ation during mos	st of work	ing	16b. k	(ind of Busi	ness/in	dustry	
.d ?	within the state of the state o	d d	Elementary/Second 10	ondary (0-12)	College (1-4or 5+)	Homem		se retired	"			Own	Home			
7:20	N DO	ပိ	17. Father's Name	(First, Middle, Las	r)		Homen	arei		18. Moth	er's Name	e (First, Middle	-				
~	ylan ouid be Mentai Arked o	To Be	Angelo F									Picar					
9	E SEE	-	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Maili	ing Address	(Street a	and Numb	er or Rura	al Route Numb	ber, City	or Town, St	ate, Zip	Code)	
2006	Te, Mi 1 and 2 Health a tem 27 is		Anthony	M. Meo	_/ so	n	619	Hille	n Ro	ad; 1	Towso	n, MD	2128	6			
5,	or He se se se se se se se se se se se se se		20a. Method of Dis	position Cremation 3 [☐Removal from		Place of Dispo cemetery, cre	osition (Nai matory or c	me of other plac	Θ)		Date	20c. L	ocation - Ci	ty or To	own, State	
٠ ۲	Pages Thent of Itant: If its		4 Donation	5 Other (Speci	fy)		ost Hol	•			5/9/	06		timor			
MAY	Baltimore , permit. Pages 1 ar Department of Healmportant: If item any injury or other	ğ	21. Signature of Fu	Interal Service Lice	750			2. Name ar				M. Artic		050 Y			
			23a. Part1. Enter t shock, or hea	the disease or con	anlications that	raused the de-	-					Нопе		owson	, MI	21204	
	Physicia /Medic Examine Examine prize and prize literation and prize lit	al	snock, or neal Immediate Cause disease or condition resulting in death) Sequentially list condition reause. Enter Unde Cause (Disease or that initiated events resulting in death)	(Final on ditions, neediate artying injury s	a. CONG Due to Due to		HEART equence of):									Approximate Interval Bets Onset and D	veen)eath
8	the death certificate by the attending physicached for use as the	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 Live	itcome of pregi birth 2 ∐Fe nant at time of lown	tal death 3[⊒Ectopic p ⊒ Other (sr						23d. Date of Month		•	/ear
	COFGS, F w requires that been signed should be del	<u>م</u>	Part II. Other signit	ficant conditions	contributing to c	leath but not re	esulting in the u	indertying o	ause give	en in Part I	I. ———		tobacco Yes 2			ne cause of do	
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SYI	VIT2 ician ician ician ician ician	B	25. Was case refer examiner?		Hospital:				000			(Check only					
	Of Phys rthis ral dir	2	1 Yes 2X		28a. Date		28b. Time of			4A N		me 5 Res 28d. Describe			(Specif	y)	
	ding P. After I	盲	1 XNatural 2 Accident	5 Pending investigation	(Mor	ith, Day Year)	Injury	″ м '	28c. Injury Work	ເ?ົ Yes 2 🔲		zod. Describe	now inju	iy occurred			
:	DIVISION of or Attending after death. I Director: After d in by the fune	Certification;	3 Suicide 4 Homicide	6 Could not to	28e. Place	e of Injury - At ling, etc. (Spec	home, farm, st					28f. Location City or To			or Rura	al Route Numi	⊃ <i>⊖г,</i>
	DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)	1X Certifying P 2☐ Medical Exa	miner: On the b	e best of my kr pasis of examination of the state of the	nowledge, deat nation and/or in	th occurred evestigation	at the time, in my or	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s , date an) and mann d place, and	er as s d due to	tated. the cause(s)	,
	To the To the comp	Σ	29b. Signature and	I title of certifier				29	c. License				29d. Da	ite signed (Month,	Day, Year)	
		'		12					1)4	377	25			5/5/	106	>	
	5		30. Name and addr														
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		State strar	MA	Y 0 8 200	6	Es Si	TO A	1500									

	1		1- For State of Maryland / De Registrer	epartment of Health Certificate of Deat	46	giene Reg. No. 005	14379
			1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day Year	3. Time of Death
	Physicia /Medic		Jane A. Meleney			2, 2006	3:15 P ^M
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death	4c. County of Death	
			Washington Adventist Hospital	Takoma Par	ck	Montgo	mery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months Days Hour	der 24 Hrs. 8. Date of Birt rs Min. (Month, Da	v. Year) Court	lace (State or Foreign
	Director		242-74-2273 1□M 2XF 87 Yr	s.	Oct. 16		ntucky
	D	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		1	0d. Inside City Limits
	anyla sho	-					1 ☐ Yes 2X No
	8a-1	ecto		Spring		10g. Citizen of What Cour	
	with t	급	10e. Street and Number	10f. Zip Code			•
	234	rai	3126 Gracefield Road	20904	Origina (Speeds Vee or No	United Sta	
	er de Itam	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	 Was Decedent of Hispanic If Yes, specify Cuban, Mexi 	ican, Puerto Rican, etc.)	Black, White,	
36	rs aft	Ž	3 ▼ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Spec	cify:	Specify:	White
21215-0036	within 72 hours after deeth with the Maryland ane. Than "natural" or itams 23a or 28a-f show he Medical Examiner must be notified at	Completed by	15 Decedent's Education 16a C	ecedent's Usual Occupation		16b. Kind of Business/Inc	dustry
5	in 72	piet	(Specify only highest grade completed)	Give kind of work done during n fe. DO NOT use retired)	nost of working	17.	
7	with iene	E	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home	
	illed Hygie other	BeC	17. Father's Name (First, Middle, Last)	18. Mc	other's Name (First, Middle,		
ä	Mental Merked o	To B	Calvin Durand Allen	Fr	cances Marsha	.11	
Maryland	2 should be filed within 72 hours after deeth with the Marylan and Mental hygiene. Is marked other than "natural", or itsms 23s or 28s-f show aumstic svent, the Medical Examinat must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Nur	mber or Rural Route Numbe	er, City or Town, State, Zip	Code)
	ロモアコ			90 Selworthy R	oad, Rockvil	le, Maryland	20854
Baltimore,	permit. Pages 1 en Depertment of Heal Important: if Itam 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 ፟፟፟ Cremation 3 □ Removal from State 20b. Place of C cemetery, Mc	risposition (Name of crematory or other place)	May 5,	20c. Location - City or To	
Ĕ	Pages nent of ant: # It ury or o	Ш		ontgomery atorium, Inc.	2006	Bethesda, Ma	aryland
a	ports y inju		21. Signatur of Funeral Service Ucensee	22 Name and Address of Fa	ecility	/Ratharda_Charry	Chaco Tro
m	88 = 8		M01420	Robert A. Pumphre 7557 Wisconsin Av	venue, Bethesda,	Maryland 2081	4 Hic.
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such	as cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	din hulmo	many (DI)	101	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of	the state of	1 1 00	7.	
ı	Examiner		Sequentially list conditions b.	ngestell	heart Ke	elle	
2/	sit ad	Examiner	Sequentially list nondition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) It was to	A	0001	
4	and I-tran	хап	that initiated events resulting in death) Last Due to (or as a consequence or	ANLIOVION	meren)/NO	
8760,	Attending Physician: The law requires that the death certificate be executed and decorated. Attention of the continuate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	ical E		- 1			
84	phys the	9	d.			-	
	ding iding se a:	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	anv.
Box	leath certific attending p	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
о. О.	by the a	Physician/Med	1 ☐ Yes 2 22No 9 ☐ Unknown		70		
	res that igned b be deta		Part II. Dther significant conditions cont/ibuting to death but not resulting in t	he underlying cause given in Pa	art I. 23e. Did t	obacco use contribute to the	ne cause of death?
sp.	uires sign	d by	Monengeles	3	10	Yes 2 ☐ No 3 ☐ Prob	ably 4XIUnknown
00	w require been sl should I	lete	Corolman I DINIII DI	annolous	24a. Was		psy findings available
Records,	he lav e has	Completed	- Colling Vivinia	California Contraction of the Co		ormed? death?	mpletion of cause of
ā	in: T ificate or, pa	ပိ	25. Was case referred to medical	ae Di	1 ☐ Yes	21	2 □ No
5	sicia s cert lirect	ToB	examiner? Hospital:	Other	Nursing Home 5 Resi		iv)
ō	ding Physician: The Ih. h. After this certificate ha funeral director, page		27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at		how injury occurred	97
<u></u>	nding th.: Afte	atio	1 XNatural 5 Pending (Month, Day Year) In 2 ☐ Accident investigation	ury Work? M 1 ☐ Yes 2	2 □ No		
Division of Vital	Atte	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (City or To	Street and Number or Rura	I Route Number,
ā	s after or all Dir	Certification:	pullating, sec. (Specify)		ony or rot	m, state)	
	lospi hour unst	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, Check of Check o				
	To the Hospitel or Attendi within 24 hours after death. To the Funsral Director: A completely filled in by the fu	Medi	one) and manner stated.	29c. License numb		29d. Date signed (Month,	
	Twit To	-	29b. Signature and title of certifier	25C. LIGHTSE HUMAN	1147	(1)	7
,	/			5	011/	3/400	
	15		30. Name and address of person who completed cause of death (Item 23a) (T Nasreen Kango, M.D. 7610 Carroll	Avenue, #205,	Takoma Park.	Maryland 2	0912
ia.	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
B	Registr		MAY 0 8 2006	Sucrete !			

Amend Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MOSES Om M ENEVA /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A SAMARITAN NURSING CENTRE HTIMORE If Under 24 Hrs. 8. Date 4000 8. Date of Birth 05/03/1931 If Under Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Virginia 1 □ M 2**X**○ F 218-26-9542 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Experiment on the mortified at once. 10a State 10b County XXYes 2 □ No Mary land Directo N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4441 LaPlata Avenue 21211 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Year'S College (1-4or 5+) Maryland Cup Company Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kathleen Clem Hubert Dofflemover ဂ္ 19b. Mailing Today 100 and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Armetta - Daughter 1811 Harford Road Baltimore, Maryland 21237 Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 05/09/2006 Towson, Maryland Hilltop Service Corp. 21. Signatural Fyne Parvice Licensee Charles F. Miner Jr. 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 POXIA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ORY Sequentially list conditions, a y bailing to mined as cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner OBSTRUCTIVE PHIMOMETRY PISEASE The law requires that the death certificate be executed burial-transit HRONIC Due to (or as a consequence of): Box 68760. Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 4 Unknown MENITUS 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? DISORDER 24a. Was an autopsy performed page this certificate h 1 Yes 2 No 2 No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Medical Certification; To After thi 27. Manner of Peat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Vision Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier address of person who completed cause of death (Item 23a) (Type, Print) BLUD BALTIMORE RAVEN KMHAEL DODOO 601 32. Registrar's Signature, 31. Date filed (Month, Day, Year) State 2006 0 8

Registrar

			For State Registrar	State of Ma		artment of Hertificate of L			ene 2006	14381
			Decedent's Name (First, Middle, L.)	ast)				2. Date of Death		3. Time of Death
	Physicia	an	Marie			Met	2110	April	30 2000	0 02:30A M
	/Medic		4a. Facility Name (If not institution, g	ive street and number)			Location of Death		4c. County of Dea	
	Examin	er	Johns Hopkins		rosoital		more		N/A	
	Funoval				(In yrs. last birthday	() If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		085-03-7492	1 M 257 E	9 Yrs.	Months Days	Hours Min.	(Month, Day, Y April 29	'ear) C	nnsylvania
			Usual Residence of Decedent					1 - 4		
	ylan.		10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Limits
	a-f s	cto	Maryland Ba	ltimore			Dundal	.K		1 ☐ Yes 2 ☑ No
	death with the Maryland rme 23a or 28a-f show r must be notified at	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
	th wi		11 S. Ship Road	đ		21	.222		Unites St	ates
	dea me	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
0	or it	F	1 Never Married 2 Married	If Yes, Give		1 ☐ Yes 2√∑ No	Specify:			Mite
2-003p	ural',	d by	3X Widowed 4 ☐ Divorced	Year or Dates:						
<u></u>	72 h	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Giv	edent's Usual Occupa re kind of work done of DO NOT use retired	durina most of worl	king	8b. Kind of Business	/Industry
V	withir	μ	Elementary/Secondary (0-12)	College (1-4or 5	+)	ousewife	/		Own Hom	TO TO
7	lied Hygie ther nt, II		8 Years 17. Father's Name (First, Middle, Lat	st)	110	Jusewile	18. Mother's Nam	ne (First, Middle, Ma		
aud	ntal h	Be	Nicholas Me					istina D'		
Š	d Me d Me mark matic	은	19a. Informant's Name/Relationship		er 19h Ma	ling Address (Street	and Number or Ru	ral Route Number (City or Town State	Zin Code)
<u>8</u>	d 2 s th an 7 is trau		Nicholas J. Meta			,		ndalk. Ma	730	1222
a)	1 an Heal em 2		20a. Method of Disposition	•	20h Place of Dist	2 Holborn position (Name of			c. Location - City or	
ğ	ages nt of nt of t: if it		Y☐ Burial 2 ☐ Cremation 3		cemetery, cr	ematory or other place nislaus Ce	e) m. 5/4/2	006	Dundalk.	Maryland
Saltimor	it. Partime		4 □ Donation 5 □ Other (Special Structure of Funeral Service Light		-	22. Name and Addres		-	Danadin	riaz y zarre-
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Signification is marked other than "natural," or iteme 23a or 28a-f show sny injury or other traumatic event, tra Medical Examinar must be notified at once.		21. Side all Control of Parish and Sources Ed	/		Duda-Ruck	Funeral	Home of D	undalk, I	
ė			23a, Part1. Enter the disease, or co	mulications that caused		7922 Wise				Approximate
			shock, or heart failure. List on	ly one cause on each lin	10.		g, 55577 45 54.5.25	or roop arony arros	.,	Interval Between Onset and Death
i	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ke	nal Fa a consequence of):	ilure				3 days
	Examiner		1	_						1
		7	Sequentially list conditions,	b. Due to for as	y dration					IWEEK
H	ited nsit	ulu.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
/	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					-
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20	law requires that the death certificate as bean signed by the attending phys 2 should be detached for use as the			u					- 12	
XOD	nding use	Ician/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
ň	death a atte d for	ca	in the past 12 months?	4 Pregnant at		I □Ectopic pregnancy I □ Other (s <i>pecify)</i> _			Month	Day Year
)	the cy by the ache	Physi	9 Unknown	9□ Unknown		2012		-		
	s thai	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
ecords,	quire in sig uld biu							1 🗌 Yes	2.25No 3□P	robably 4 Unknown
ပ္ပ	s bee	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Ë	0 = 0	E C						autopsy performe	d? death?	s 2 No
VITAI H	vician: The certificate rector, pag	Ö	25. Was case referred to medical		2.7 1		26 Place of Dea	1 ☐ Yes 2∫ th (Check only one)	2 1	S 2 NO
>	Phyeician: r this certific ral director,	OB	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/Outpati	ent 3 DOA Oth		ome 5 Residen	ce 6 ∏Other (Spe	ecify)
0	iding Phyeician: th, : After this certifica funeral director,	T:U	27. Manner of Death	28a. Date of Inju (Month, Da		of 28c. Injur		28d. Describe how		
0	ndin th. r: Aft	ate	Natural 5 Pending 2 Accident investigat		y Yea <i>r)</i> Injury		Yes 2 □No			
UNISION	Atte	=	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm,	street, factory, office		28f. Location (Stre City or Town,	et and Number or F	lural Route Number,
5	s afte	Certification:	, , , , , , , , , , , , , , , , , ,	Dullaning, or	o. (opecity)			ony or roun,	olulo)	
	To the Hospital or Attending Pl within 24 hours atter death. To the Funerel Director: After it completely filled in by the funera		29a. Certifier Certifying	Physician: To the best aminer: On the basis of	of my knowledge, de	ath occurred at the tin	ne, date and place	, and due to the cau	ise(s) and manner a	s stated.
	the hin 24 the F	Medical	one)	and manner sta	ited.					
,	To To	Σ	29b. Signature and title of certifier	. 11 7		29c. Licens			d. Date signed (Mon	
)			Findy Segulor	- 70.9.		Res	_000	A	pril 3010	2006
	10		30. Name and address of person wh							
	W		Emily Sydnor T	ne Johns H	opkins Hos	pital 600	North Wol	ife Street Bo	1 timore 1 MA	iryland 21287
70	Sta		31. Date filed (Month, Day, Year)	2. Registr	ars Signature	well .				
	Registr	al	MAY 0 8 20	UD TRANSPORT	100					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Donnell Eric Overby 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ 1030 hrs Medical Examiner Donne 11 April 30, 2006 Eric Overby 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2723 Giles Rd. Cherry Hill 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreian Months Days Hours Director Country) Maryland 217-08-4238 1 X M 2 Yrs 04/16/1974 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 'n 1 X Yes 2 No Maryland Baltimore with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 2126 Walbrook Avenue 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death v Armed Forces? 1 XNever Married 2 Married 2X No Yes ō Specify Black nours after Divorced If Yes. Give Year Yes 2 X No specify Widowed "natural". à 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 innert of Health and Mental Hygiene.
Trant: If item 27 is marked other than on other traumatic event, the Medical Baltimore, MD 21215-0036 Forklift Operator Solo Cup 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Peggy Martin Be Lazarus Overby
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2126 Walbrook Avenue, Baltimore, Maryland 21217 Lazarus Overby / Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 XCremation 3 Removal from State crematory or other place) 05/08/2006 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify 22 Name and Address of Facility The Derrick C. Jones F/H, P.A. Signature of Funeral Service 4611 Park Hgts. Ave., Baltimore, Maryland 21215 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a Part I Enter the disease, or complic **Physician** failure. List only one cause on each Between Onset and /Medical Death Mixed drug intoxication (methadone, cocaine, tramadol) Immediate Cause (Final disease а Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Cal item#23a,27,28a-f,perME,g855,5/25/06 TT X UNPENDED Physician/Medi 23d. Date of delivery IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown

To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by Medical

Š Completed Be 2 Certification:

25. Was case referred to medical

No

Pendina

6 X Could not be

Investigation

determined

2008

examiner?

1 🗸 Yes

27. Manner of Death

Natural

Accident

Suicide

Homicide 29a Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (NMA) (Year)

2

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 32 Registrar's Signature

Unknown

Hospital: 1 Inpatient 2

28a. Date of Injury (Month, Day,Year

(Specify) unk

Fnd 4/30/2006

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ER/Outpatient 3

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Fnd 10:15 AM

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

23e. Did tobacco use contribute to the cause of death?

24a Was an

ıınk

26 Place of Death (Check only one)

Other₄

1 Yes 2 No

28c. Injury at Work?

29c License number O.C.M.E.

DOA

autopsy

performed?

Nursing Home 5 Residence 6 V Other Scene

28d. Describe how injury occurred

✓ Yes 2 No

1 Yes 2 No 3 Probably 4 Unknown

death

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2723 Giles Road Baltimore, MD

May 1, 2006

29d. Date signed (Month, Day, Year)

1 🗸 Yes

24b. Were autopsy findings available

prior to completion of cause of

2 No

		Pleas	State of		Departmen			-	_	ic.	
		1 - State	State of	iviai ylai lu /	Certificate				g. Nó 0 0	5 143	183
1 10		Registrar 1. Decedent's Name (First, Middle,	Last)			0.0.000.		2. Date of Deat	h	3. Time of	Death
Physic		Elizabe	th 0	LIVER	2			Month OH		1030 1030	, A M
/Med Exam		4a. Facility Name (If not institution,		oer) 5009	4b. City,	Town, or Locatio	on of Death	MORE	4c. County of		
	A	LORIEN Frai	kford A	FRANKF	trongo MD	21206	MI	•		MOREC	
Funera	_		5. Sex 7.	Age (In yrs. last b	Yrs. 1f Under Months	Days Hours		8. Date of Birth (Month, Day,	Year	9. Birthplace (State of Country)	or Foreign
Directo		250360865 Usual Residence of Decedent		80	113.			Dec 17	1920		
yland		10a. State 10b. County			wn or Location					10d. Inside Ci	
a-f-e	ctor	MD		130	iffimor	e				1 Yes	2 □ No
death with the Maryland ms 23e or 28a-f ehow	Funeral Director	10e. Street and Number			10f. Zip		Cl	11	0g. Citizen of Wh		
s 23e	ral		Ford Au 12. Was Deced		12 Was Dass	2121		oifu Vac or No	US 14 Baco	- American Indian,	
after dea or items	-un-	11. Marital Status 1 Never Married 2 Marne	Armed Forc	es? ▼No	If Yes, spec	dent of Hispanic of Cuban, Mexic	ican, Puerto F	Rican, etc.)		White, etc.	
hours after tural', or ite	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	9S:	1 🗆 Yes	2 No Speci	eity:		Specify:	Black	
3-UU30 72 hours after death v neturel; or Items 23e	Completed	15. Decedent's	Education grade completed)	16	a. Decedent's Usua (Give kind of wo	rk done during m	nost of workin		16b. Kind of Busi	ness/Industry	
I dithin	mpl	Elementary/Secondary (0-12)	Coltege (1-4	lor 5+)	life. DO NOT us	,	~		min	istry	
lied v		17. Father's Name (First, Middle, L	ast)		Cler	94 WO	mun Name	(First, Middle, A	Maiden Sumame		
d be f	To Be	William	Jam	PC		R	anh	01	luda		
shoul nd Me	F	19a. Informant's Name/Relationsh			b. Mailing Address	(Street and Nur	mber or Rural	Route Number.	City or Town, S.	tate, Zip Code)	
ind 2 alth a 27 le		Regina Lei	uis-do	ece alter	2609	Bidd	le St	- Bul	16. M.	1 212	13
Ore ges 1 s t of He if item or oth		20a. Method of Disposition 1 X Burial 2 Cremation	3 DRemoval from St	comet	of Disposition (Nar ery, crematory or o	ne of ther place)	Mich	ate 2/VY	20c. Location - C	ity or Town, State	
7 2 8 8 B		'4 □Donation 5 □ Other (Sp		Arb	utus N	emoria	al	n, neces	Arput	ity or Town, State)
Balti Permit. Departm Imports eny inju		21. Signature of Juneral Service L	icensee		22. Name an	d Address of Fa	icility TR	i-Stay	e hur	revalser	VILLES
2 40300	1	any /	Mico	read the death. Dr	not enter the mod	Georg	1a An	R N.L	v. wu	Approximat	KOUII
6a	4	23a. Part 1. Inter the disease of shock or heart failure. List of Immediate Cause (Final	nly one cause on eac	sh line.	0 /	1	45 041 4140 01	rospilatory arre	, ,	Interval Bet Onset and I	tween
Physiciar /Medica		disease or condition resulting in death)	a. Pue to (or	as a consequence	niephlo	parry		-			
Examine				as a consequence	o 01).	,					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence	e of):						
ecutec ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с								
/ 6U, te be executed ysician and te burial-transit	cai E	rossiting in doatily East	Due to (or	r as a consequenc	e or):						
ificate ilicate g physi as the t			d								
	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy					23d. Date	of delivery	
death cer death cer death cer deattendir	Cla	in the past 12 months?	4☐Pregnar	h 2 Fetal dea nt at time of death	th 3 ☐ Ectopic pr 5 ☐ Other (sp				Mont	h Day	Year
	hys	9 Unknown	9□ Unknow	n							
S, es th	by F	Part II. Dther significant condition	ns contributing to dea	th but not resulting	in the underlying o	ause given in Pa	art I.			oute to the cause of c	death?
w require	ted							1 L Y 6			
() × D 0	Completed							24a. Was ar autops perform	n 24b. We	ere autopsy findings for to completion of c ath?	available ause of
r VITAI HEO ysician: The lav is certificate has director, page 2		05 W						1 ☐ Yes 2	No 1E	Yes 2⊠No	
	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nationt 2 PR/	Outpatient 3 DC	Other	_	(Check only on	e <i>)</i> ence 6 ⊡Other	(Specify)	
O E = E	n; To	27. Manner of Death	28a. Date of			28c. Injury at Work?			w injury occurred		
ttending I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investig	ation	Day real)	М	1 Yes 2	! 🗆 No				
DIVISION Or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could n 4 Homicide determine	ot be ned 28e. Place o building	f Injury - At home, g, etc. (Specify)	farm, street, factor	, office	2	8f. Location (St. City or Town	reet and Number 1, State)	or Rural Route Num	nber,
Urs af											
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter	Medical	29a. Certifier 1 Cartifying (Check only 2 Medical E	Physician: To the bi xaminer: On the bas and manne	is of examination a	ge, death occurred and/or investigation	, in my opinion, o	and place, a death occurre	ed at the time, da	ause(s) and mani ate and place, ar	ner as stated, id due to the cause(s	s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			290	c. License numbe	er	2	9d. Date signed	(Month, Day, Year)	
7	make an artist of	Man M				DJ7	727	- 1	4/26/0	de	
1		30. Name and address of person v	no completed cause	of death (ttem 23a	i) (Type, Print)	1 1	F. m	D.	111	10000	27
le		31. Date filed (Month, Day, Year)	Bharas	8-1	renne	4/19ll	2	Dung	alk.	1/2/11/2/5	((
S Regis	tate	1481/0 -	2006	gistrar's Signature	Break .						
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DHMH 17 Rev 1/2001

ORIGINAL

		For State	ase i	_			d / Depa	artment	of H	lealth and i	Mental Hy	giene	2006	No. of	384
1000	T.	Registrar 1. Decedent's Name (First, Midd	die. Last				Ce	rtificate	01 1	Deam	2. Date of De	Reg. No."	. 0 0 0	3. Time o	of Death
Physicia		Leo P. O'Hare	,,								May Month	4 ^{Day}	Ž06	6:0	
/Medic		4a. Facility Name (If not institution	on, give	street and nu	mber)			4b. City, To	own, or	Location of Death			County of Death	1	
	24 TO	Hospice of Bal											altimore		
Funeral Director		5. Social Security Number 218-03-0958	6. Se	X M 2□F	7. Age	(In yrs.	last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 0Ct 10,	191	9. Births	lace (State	or Foreign
D ₂		Usuaf Residence of Decedent								1					
aryiar	j.	MD Balti	•	2			y, Town or Lo enix	cation					1	0d. Inside C 1 ☐ Yes	City Limits ≥ 2 X No
C & OSAM 1215-0036 within 72 hours after death with the Maryland ene than "natural", or Items 23a or 28a-f show than Madical Exemples notified at	Completed by Funeral Director	10e. Street and Number			1			10f. Zip C	Code			10g. Citiz	en of What Cour		-/\
th with	a D	3 Siesta Garth	1					211	31			USA			
- dea	iner	11. Marital Status		12. Was Dec Armed Fo	edent E	ver in U	.S. 13.	Was Decede	int of Hi	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No	- 1	4. Race - Americ Black, White,		
38 38 safte s's afte	yFι	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried	1 (X)Yes If Yes, Gi Year or D	2 □ N ve	0		1 □ Yes 2[Specify:			Specify: wh		
21215-0036 d within 72 hours all giene. It has "natural, or the Medical Exemple.	ted t	15 Decede	nt's Edu	cation	ales.		16a. Dece	dent's Usual	Occupa	ation		16b. Kin	d of Business/In	dustry	
215 215 215 8. "n	uple	(Specify only high Elementary/Secondary (0-12)		e completed) College (1-4or 5-	+)			done d retired	ation during most of wor ()	king		ed State		
of filed within all Hygiene.	Cou	12	(224)				Super	visor		10 14-15-1 1	- (E) - A A A - (-1)		al Serv	ice	
Maryland d 2 should be fit th and Mental H 7 is marked out traumatic even	To Be	17. Father's Name (First, Middle Edward O'Hare	, Last)							18. Mother's Nam Agnes T			sumame)		
Itimore, Maryland 21215-0036 Int. Pages 1 and 2 should be filled within 72 hours after death with the Marylar arment of Health and Mental Hygiene. Ordent: If item 27 is marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at a.		19a. Informant's Name/Relation Anne 0'Hare		_{грө, Print)} daught	er		19b. Mailir 3 Si	ng Address (esta G	Street a	and Number or Ru h; Phoen	ix, MD	er, City or 21131	Town, State, Zip	Code)	
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Importent: If item 27 is any Injury or other tra		20a. Method of Disposition	۰.۵		0	20b. F	Place of Dispo emetery, crei	sition (Name	e of er plac	e) !	Date	20c. Loc	ation - City or To	wn, State	
Baltimore, Baltimore, Permit. Pages 1 a Department of He importent: If item any Injury or other pance.		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State	Wo	odlawn	Cémet	ery	5/8/	06		imore,		
Balt Balt Barnit. Departimport import any inj since.		21. Signature of Filmeral Service	Licens	80				. Name and			4		50 York		. 4
10		23a Part 1 Enter the disease		ications that	aucod:	the deat				n Funera			wson, M	Approxima	
Physician	Ė	23a. Part1. Enter the disease, shock, or heart failure. Listing immediate Cause (Finaf	st only or	ne caluse on e	ach line	θ.	+ 19	000	or dynn	moni	Δ	11651,		fnterval Be Odset and	tween
Physician /Medical	8	disease or condition resulting in death)	-	Due to	(or as a	conseq	uence of):	///			<i>V</i> 7			JAY	15
Examiner		Sequentially list conditions		D											
The state of the s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ł	Due to	(or as a	conseq	uence of):								
60, be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last		Due to	(or as a	conseq	uence of):								
OX 68760, ox certificate be executed inding physician and use as the burial-transit	calE			4											
68' tifficati tifficati tig phy as the															
FRE Cords, P.O. Box 68 Records, P.O. Box 68 The law requires that the death certifica are has been signed by the attending phagge 2 should be detached for use as the state of the state as the state of the st	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, out				Ectopic preg	gnancy			23	3d. Date of delive	*	Mana
P.O. B. that the death detected for detected for	slcl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∏Pregr 9∏Unkn	nant at t			Other (spec					Month	Day	Year
S, P.(se that the igned by be detact	Ph	Part II. Other significant condit	ions cor	ntributing to d	eath bu	t not res	ulting in the u	nderlying cau	JSB QIVE	en in Part I.	23e. Did t	obacco us	e contribute to the	e cause of	death?
rds,	d b	Obstruc-	too	2 (U	ng	- 1	SEMS				1 🗆 '	Yes 2	No 3□Prob	ably 4 🗆	Unknown
Record he law requir	Completed	GNOMAN	11	Arte	1	d	SEA	50			24a. Was		24b. Were auto	osy findings	available
Vital Recipion: The law	mo.	congest	zv	· He	un	1	FAC	(UVe			autor perfo	osy rmed?	prior to co death? 1 \(\sum \text{Yes}	npletion of a 2□ No	ause of
	Be	25. Was case referred to medic examiner?								26. Place of Dea		-		71	
Vision of Vital Vision of Vital Attending Physicien: r death. sctor: After this certific by the funeral director,	2	1 Yes 2 No	,				ER/Outpatier		1	4 Li Hui Sirig I I	ome 5 Resi			Hos	PICE
On On Ging	tlon	1 Natural 5 ☐ Pend	ing tigation	28a. Date (Mon	th, Day	Year)	28b. Time of Injury	M 280	C. Injury Work	Yes 2 No	28d. Describe I	now injury	occurred		
Division or Attending after death. Director: After time in by the tune	Ifica	3 Suicide 6 Could	-	28e. Place	of Injui	ry - At ho	ome, farm, str	eet, factory,	office				Number or Rura	l Route Num	n <i>ber</i> ,
Div Div rs after el Dir	Certification:	4 D HORNEGO		build	ng, etc.	. (Specif	v) 				City or Tou	vn. State)			
	Medical	29a. Certifier 1 Certify (Check only one)	ing Phys I Exami	sician: To the nar: On the b and man	asis of (examina	wledge, death tion and/or in	occurred at vestigation, in	the tim	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as solace, and due to	ated. the cause(s)
To the within To the comple	Me	29b. Signature and time of certific	er /	,	1	50		29c. I	License	number	_	29d. Date	signed (Month,		
		1/1/ Km	TI	my 1	16	Kr), w	10 1	1)0	1200		m	77 4	2006	
1041		30. Name and address of perso	200 ce	mpleted caus	se of de	ath (Item	23а) (Туре,		01	N. CHA	ARLES.	STRE 14	€T		
Stat		31. Date filed (Month, Day, Yea		61	ogistra	r's Signa	ture	ask s	J (VV	3014, 7.1.					
Registra	ar	MAY 0	8 20	UD A	MES CO	Rose d	a. Will	Strugger of the strugger of th							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistrerAmend #1 Per Phy G855 5/10/08 effificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year John John Louis Pfeifer 415 AM /Medical May 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death (In yrs. last birthday, 01 Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXI 2 F Hours 217-05-3722 88 Yrs. Director 8-4-1917 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Harford Director Md 1 ☐ Yes 2 XNo Harve De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Tern Court 21078 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Levison & Klein Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Accounts Recievable Furniture Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John G. Pfeifer Mary (Greene) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matilda Pfeifer/Wife 505 Tern Court Harve De Grace, MD 21078 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 5-8-06 Oaklawn Cemetery Baltimore, MD permit.
Dep. rtr
Importe
any ni 22. Name and Address of Facility Cvach / Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 CHesaco Avenue Rosedale, Md 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Hyperkalemia Z days /Medical Due to (or as a consequence of): **Examiner** Acute renal day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician pe Physician/Medical as the b IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Mediastinal malignancy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

a State Registrar

ం

31. Date filed (Month, Day, Year)

29b. Signature and title of certifies

Johns Hookins Hospital 32. Registrar's Signature

JU

D0062803

29c. License number

29d. Date signed (Month, Day, Year) May Z006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Riedel MD

600 N Wolfe St.

MAY 0 5 2006

06-02968 Michael Jason Philpott

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 14386

		1- For State Cer	tificate of D	eath		Re	⊈. U €.	1930
Physicia	n/	Decedent's Name (First, Middle,Last)				Date of Deat Month	h Day Year	3. Time of Death
ledical Examii	ner	MICHAEL JASON PHILPOTT				May 2, 200	06	0720 hrs
		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		City, Town, or Loc Innapolis	cation of Death		4c. County of Dea Anne Arunde	
Funeral	\neg	5. Social Security Number 6. Sex 7. Age (In yrs. la	- · · · -		If Under 24Hrs.	8. Date of Birt	h (MM/DD/YYYY) 9. 8 Fore	
Director		212.08.4091 1XXM 2 F 22 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	MAY 1,		ountry) MD
any	ŀ		Town or Location			-		10d. Inside City Limits
* .	5	MD ANNE ARUNDEL ANNA	APOLIS					1 Yes 2 XXNo
e Maryli or 28a-f	Director	10e. Street and Number 2021 HARBOUR GATES DR.	10	of, Zip Code 21401		10	og. Citizen of What Coi USA	untry?
with th		11 Marital Status 12 Was Decedent Ever in U.S.	S. 13. Was D	ecedent of Hispar	nic Origin? (Sp	ecify Yes or No-		rican Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matie event, the Medical Examiner must be notified at once	Funeral	Never Married 2 Married Armed Forces 1 Yes 2 No 13 Widowed 4 Divorced If Yes, Give Year		specify Cuban, Ms		Rican, etc.)	White, etc. Specify: W	HITE
ours af atural	d b	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's l	Isual Occupation	(Give kind of w		16b Kind of 8usiness	
136 thin 72 ho ne than "na edical Ey	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10		of working life. DO		ea)	CONSTR	ICTION
d with	Ĕ	17. Father's Name (First, Middle, Last)				(First, Middle, N	Maiden Surname)	CITON
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	a	JOSEPH GEORGE PHILPOTT, JR		(CYNTHIA	SHANKL	IN	
e, MD 21215-003 I and 2 should be filed withi Health and Mental Hygiene 'tiem 27 is marked other the	2	19a. Informant's Name/Relationship (Type, Print) CYNTHIA SHANKLIN MOTHER					ber, City or Town, State R, MD 21619	
Tore, I ages I and nt of Healt t: If item other trau			Place of Disposition rematory or other i		ery,	Date	20c. Location - City of	r Town, State
E 6 6 5		4 Donation 5 Other Specify: G	BEEN LANE		5.7	2006	DELRAY, 1	JEST VIRGINIA
Balti permit Departn Import injury		21 Signatule of Funeral Service Lidensee K. GREGORY FINK MO1148		FUNERAL				
Physician	-	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the n	node of dying, suc	ch as cardiac o	respiratory arre	est, shock, or heart	
/Medical		failuce. List only one cause of each line. Immediate cause (Final disease a. Narcotic intoxica	ation comp ¹	icated by	drowning	r		8etween Onset and Death
.xammer		or condition resulting in death) Due to (or as a consequence of		122700000000000000000000000000000000000				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	·):					
_	Examiner	Obsease or injury that initiated events resulting in death) Last	5:					
ecuted and - transi		d.	2- 27 20- 4	- ME O	FF F /10 /0	- TTI		
760, cate be ex physician he burial	n/Medical		3a,27,28a-f	pen'E,ga	55,5/10/0	6 TT	Tool Division	
18760, rifficate be ing physic as the bur	Ž.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr		teath 3	Ectopic pregna	ncy	23d. Date of delive Month	ry Day Year
Box 687 e death certific the attending p	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown	cth	(Specify)				
P.O. Be	F	Part II. Other significant conditions contributing to death but not re	sulting in the unde	rlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S, P.C	d by						2 No 3 Pro	obably 4 🗸 Unknown
Records, The law require ficate has been si	Completed					24a. Was a autop	sy prior to	utopsy findings available of completion of cause of
Rec The la icate h	ĕ					perfor		es 2 No
tal Rection: The certificate	Be	25. Was case referred to medical examiner?		IOH	Death (Check o			
Physic rathis	2	1 Yes 2 No	ER/Outpatient 3				Residence 6 Othe	er [.]
Division of Vital ral or Attending Physician rs after death. al Director: After this certiced in by the funeral director.		1 Natural 5 Pending (Month, Day, Year)	28b. Time of Injur	1 Yes	0 == 11	unk	now injury occurred	
ision Attender Per death rector: by the	icat	2 Accident Investigation Pnd 5/2/2005 28e Place of Injury - At ho	Fnd 6:30 A	11			treet and Number or R	ural Route Number, City
Div iital or urs aftu ral Di	ertification:	Suicide 6 X Could not be determined (Specify) found at			J.	or Town, S Annapolis	tate) 2021 Harbo	our Gate Drive
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge one) Physician: To the best of my knowledge one) Physician: To the basis of examination and the basis of exam				due to the caus	e(s) and manner as sta	
T ₀ To	Me	29b Signature and title of certifier		29c. License n	umber		29d. Date signed (M	onth, Day, Year)
		- Feller - Poller -		O.C.M.	E.		May 3, 2006	
g		30. Name and address of person who completed cause of death (Item		Id Dema Ct	-4 D-14:	- MD 0400		
0		Patricia Aronica-Pollak MD. Assistant Medical E		1 Penn Stree	et, Baltimor	e, MD 21201		
St Regist	ate rar		ire Angel	e				

06-02971 David Porter Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				of Death	ind Mcn	tai i iygiciic	Reg. N	. 200	16	1438
Physici Medical Exami		1. Decedent's Name (First, Midd	,					Date of Month	Death Da		3. Time (
VIEUICAI EXAIIII	ner	David KOD 4a. Facility Name (if not institution	ert Porter	\		4b. City, Town,	or Location (May 2,	2006	4c. County of Dea	1205	hrs
		18800 Roxbury Road	, give energial names.	,		Hagerstov		or Death		Washington	ati i	
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs, I	ast birthday)	If Under 1 Y			of Birth (M	M/DD/YYYY) 9. E		tate or
Director		393-34-5385	1XM 2 F	66	5 Y	rs. Months D	ays Hours		3.	1939 Fore	-	<u>llinois</u>
any		Usual Residence of Decedent 10a State 10b. County		10c City	Town or Loc	otion						
. ≥				TOC. City,								de City Limits
th the Maryland 23a or 28a-f show notified at once.	Director	PA Che 10e. Street and Number	ster	<u> </u>	Exto	n 10f. Zip Code	,		10a C	Citizen of What Co		X
the Ma a or 21 tiffied	Dire	504 Summercro	ft Drive			193						
hours after death with the Maryland natural", or items 23a or 28a-f sht Examiner must be notified at once	Funeral	11. Marital Status	12. Was Decedent			as Decedent of I	Hispanic Orig	jin? (Specify Yes o	r No-	United S 14 Race - Ame		ı, Black,
r death	Fun	1 Never Married 2 Ma	1 Yes 2	X No	"			Puerto Rican, etc.))	White, etc.		
rs afte ural", miner	þ	3 X Widowed 4 Div	orced If Yes, Give Year or Dates:	anleted)	11	J		kind of work done	1401	Specify Wh:		_
61 3	Completed	Elementary/Secondary (0-12)	College (1-4 or			most of working li			160	. Kind of Business	s/Industry	
5-0036 led within 72 Hygiene. I other than '	mpl		4		A	rchitect	:		A	rchitect	ual F	irm
MD 21215-0036 2 should be filed within 72 h and Mental Hygiene. 27 is marked other than " matic event, the Medical.)		17. Father's Name (First, Middle,	•				18.Mother	's Name (First, Midd				
2121 ould be fi Mental I marked	o Be	William Porte 19a Informant's Name/Relations			10b Maili	as Address (St	Ec	ina Carpe	nter			
MD 2 rd 2 shou ulth and I m 27 is r	-	Daniel G. Por										•
imore, MD 21215-0036 Pages I and 2 should be filted within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than or other traumatic event, the Medical		20a. Method of Disposition			Place of Disper	osition (Name of o	cemetery,	Drive, E	200	Location - City of	LVan1a or Town, Sta	1 19341 te
MOI Pages ent of int: I		1 X Burial 2 Cremation 4 Donation 5 Other Sp			-	e Cemete		May 7, 20		ockville	Mars	uland
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		21. Signature of Funeral Service		KOC	22 122	Name and Addre	ess of Facility	Robert A	Pur	nphrey Fi	ineral	Home,
		(flugfatte Our		1305		Rockvill	e, Mar	Robert A 300 W. I yland 208	350 8	gomery A	venue,	
Physician /Medical		23a. Part . Enter the disease, or failure. List only one cause	on each line.		Do not enter	tne mode of dyin	ig, such as ca	ardiac or respiratory	arrest, s	hock, or heart	Approxi Betwee	mate Interval n Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensi Due to (or as a conse			rotic card	liovascu	lar disease	2			Death
		Sequentially list conditions,	b									
*	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of	f):				-			
W = ±	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of	f):						+	
executed ian and ial - transit		V	d	1100	o= 1	5 65 5 5 7					-	
o, o	/Medical	X UNPENDED			· · · ·	Æ,G855,5/	12/06 T	T				
3876 rtificate ing phy as the		23b. Was decedent pregnant in the past 12 months?	e 23c. If yes, outcome 1 Live birth	ne of pregr		etal death 3	Ectopic	pregnancy	2	3d. Date of delive Month	ry Day	Year
Box 68 e death certif the attending	Physician		4 Pregnant at	time of dea	oth .	ther (Specify)			Ì			
the de charter by the	Phy	Part II. Other significant conditi	9 Unknown	but not re	esulting in the	underlying cause	a given in Par	rt	id tobacc	o use contribute to	the cause	of death?
ires that the signed by it is detached	l by				J	,	gironini			No 3 Pro	_	_
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							24a. W		24b. Were a		
eco he law te has	dmc								utopsy erformed	death?	completion	
ital Recional The certificate	انه	25. Was case referred to medical				26.Pla	ce of Death (Check only one)	es 2	No 1 🗸 Y	es 2	No
Vit;	TO B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2	ER/Outpatier	nt 3 DOA	Other ₄	Nursing Home 5	Resid	dence 6 🗸 Othe	er: Scene	
1 of Jing Pl After funeral		27. Manner of Death 1 X Natural 5 Road	28a. Date of Inju (Month, Day, Yo	ry ear)	28b. Time of		jury at Work?		be how ir	njury occurred		
ivision or Attendafter death Director:	cati	- Fellu	tigation				Yes 2					
Divi	Certification:		d not be mined (Specify)	ury - At no	ome, rarm, stre	eet, factory, office	bullding, etc		n (Street n, State)	and Number or R	ural Route N	lumber, City
Hospi 24 hou Funer tely fil		20a Codifier	ysician: To the best of my	/ knowledd	ie, death occi	urred at the time.	date and plac	ce, and due to the c	ause(s) a	and manner as sta	rted	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifuln 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Exam	niner: On the basis of exar	nination ar	nd/or investiga	ation, in my opinio	on, death occ	curred at the time, d	ate and p	lace, and due to the	ne cause(s)	
F S F O	Ĭ	29b Signature and title of certifier		00		29c. Licer	nse number		29d	Date signed (Mo	onth, Day, Ye	ar)
7) &		tabello	ni - to	lles	2	0.0	.M.E.		Ma	y 3, 2006		
Spor		30. Name and address of person Patricia Aronica-Pollak	·	,	,	111 Donn 9	Street Dal	timore, MD 21	201			
	ate	31. Date filed (Month, Day, Year)	32 Registrar				Jucci, Ddl					
Regist		MAY 0 8	81		S AND	este						

			1 - For State Registrar	tate of Mar	-	partment of Fertificate of			giene ()	06	14388
	¥1		Decedent's Name (First, Middle, Last)					2. Date of De.	ath		3. Time of Death
	Physic		Joseph Ralph					April	22. 2	Year 2006	11:00PM
,	/Medi Examir		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, o	r Location of Death			ty of Death	11.001
			Baltimore Washing	ton Med	Ctr	Glen	Burnie		Anne	. Aru	ınde 1
	Funeral		Social Security Number 6. Sex	7. Age ('In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.		h		place (State or Foreign
L	Director		097-12-8610 18 M	2 🗆 F	84 Yrs.	Months Days	Hours Min.	03/05	/1922	Cour	NY
	pu ,		Usual Residence of Decedent		- 0:: -						
	anyla hov	-	10a. State 10b. County		Oc. City, Town or					'	10d. tnside City Limits
	8a-f	cto	MD Anne Arun	idel	Pasade	na					1 ☐ Yes 2 X No
	or 2	100	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath v 23e	-B	7871 King's Arm			2112	2		U.S.	Α.	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinar must be notified at 2008.	Completed by Funeral Director	1 Never Married 2 Married	Was Decedent Eve Armed Forces? 1 Mayes 2 ☐ No If Yes, Give	1944-	I. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Bla	ace - Americack, White,	
Maryland 21215-0036	ind.	d b	3 Widowed 4 Divorced	Year or Dates:	1946	12 103 2 23 110	opecity.		Speci	"y: Wh	ite
2	72 h	ete	15. Decedent's Education (Specify only highest grade co	on <i>mpleted)</i>	(Giv	edent's Usual Occup	durina most of wor	rking	16b. Kind of 8	Business/In	dustry
7	Aithin ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired	1)				
2	led w lygien lygien lygien lygien lygien	S	12		In	spector					e Plant
Ē	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan			me)	
$\frac{1}{2}$	ould Men marke	2	James Ralph					ine Pa			
Ja	2 sh and ls m	6 1	19a. Informant's Name/Relationship (Type,	•		ling Address (Street					
di di	and fealth m 27		Marie Ralph / Wi			l King's	Arm Ct	-			
0	f of t		20a. Method of Disposition Entombro 1 Burial 2 Cremation 3 Remo	ment oval from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other plac	θ)	Date	20c. Location	- City or To	own, State
٥	men tant: jury		4 Donation 5 Nother (Specify)			aven Mem					
Baltimore,	Depar Depar Impor eny In		21. Signature of Fonerat Septice Licensee								Home, PA
_	Q □ E € Ø		Maple			169 Rivi				, MD	21122
Å	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complication shock, or healt failure. List only one can timediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Renal Due to (or as a c	Failur(consequence of): Bowel			or respiratory at			Approximate Interval Between Onset and Death
o,	icate be executed physicien and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of);						
8760	ate b hysic the b	dical	d. =							_	
9	e as	Mec	IF FEMALE:								
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	lf yes, outcome of i 1⊡Live birth 2 { 4⊡Pregnant at tim 9⊡Unknown	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)				ate of delive onth	ery Day Year
J	that	P	Part II. Other significant conditions contribu	uting to death but n	not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
Sp.	ures sign	Q P						1 🗆 Y	'es 2□No	3 🗌 Prob	ably 4 Unknown
Ö	w requir been si should	ete						040 1460	0.41	14/	
Records,	The lay	Completed						24a. Was autop perfor	sy med?	prior to con	psy findings available mptetion of cause of
Vita		0	25. Was case referred to medical		de Marie		26. Place of Dea		7.0	T Tes	261140
	yeici is ce direc	ToB	examiner?	itat: 1 1 Inpatient	2 ER/Outpatio	ent 3 DOA Othe		ome 5 Resid	77	her (Specifi	v)
o uo	iding Ph th. : After th funeral		27. Manuer of Death 1 (2) Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Ye	ear) 28b. Time Injury	Work		28d. Describe h			,,
Division of	il or Attendi after death Director: A d in by the fu	Certification:	2 Suicide 6 Could not be	8e. Place of Injury buitding, etc. (- At home, farm, s Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Num m, State)	ber or Rura	d Route Number,
	To the Hospital or Attending Phyeician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of n On the basis of ex and manner stated	amination and/or i	ath occurred at the tim	ne, date and place, pinion, death occur	, and due to the or rred at the time, o	cause(s) and m date and place,	anner as st	tated. the cause(s)
)	To the I	M	29b. Signature and title of certifier	M		29c. License	3977		29d. Date signe	ed (Month,	Day, Year)
2)11		30. Name and a dress if person who comple	eted cause of deat	h (Item 23a) (Type	Print)	no Na	0 2106	. 1		
	Sta	te	31. Dale filed (Month, Day, ear)	32. Hanistra) s	Signature	www DWT	111				
	Registr	-	ERRY O O DOO		Je.	house !					
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	State of Maryland / Department of Health and Mental Hyg	giene	0 (

		1 - For State Registrar	State of Mary		artment of Hea rtificate of Dea			ene () () (g. No.	5 14389
Physic	cian	1. Decedent's Name (First, Middle, La $AUDREY$	st)	RAH	иЛ		Date of Death Month	Day Yes	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give	re street and number)	/\An	4b. City, Town, or Loca		MAY	03 200 4c. County of D	
Funera Directo				yrs. last birthday)	If Under 1 Year If U	ACTIMO Jnder 24 Hrs. 8. burs Min.	Date of Birth	1 92 1 Bal	Birthplace (State or Foreign Country) MD
and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
Maryl a-f ehc	tot	MD Baltim	ore City	•	imore				M∑Yes 2 No
ith with the 23a or 28i	ai Direc	10e. Street and Number 1236 Cleveland S	t. Baltimor	e MD	10f. Zip Code 2123	0	10	g. Citizen of What USA	Country?
n 72 hours after death with the Maryland "netural", or Itama 23a or 28a-f ehow adical Expreliant oual be netified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispan f Yes, specify Cuban, Me I ☐ Yes 2√ No Sp	nic Origin? (Specify exican, Puerto Rica pecify:	Yes or No- an, etc.)	14. Race - A Black, W Specify: W	
thin 72 hours aft e. en "natural", or Madical Exemi	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	1	6b. Kind of Busine	ss/Industry
¥ 6 € €	dmo	Elementary/Secondary (0-12) 9 th	College (1-4or 5+)		nine Operato	or		Made	Tinse1
ould be filed Mental Hygi arked other	Be	17. Father's Name (First, Middle, Last			18. (Mother's Name (Fi		aiden Sumame)	
D & 50	ပ္	James Andrew Rahi 19a. Informant's Name/Relationship (10h 14-15-		Pearl May		-	
s 1 and 2 shou of Health and M Item 27 ie mar other traumat		Calvin R. Rahm		701 (d. Linthi	.cum He	ights Ma	ryland 21090
permit. Pages 1 a Department of Hee Important: if Item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 □ Donation 5 □ Other (Specif	Removal from State L	ob. Place of Dispo cemetery cren oudon Pai	sition (Name of place) natory or other place) CK Cemetery	05/06/		Oc. Location - City 1timore	
Deparit Deparit Import		21. Signature of Funeral Service Licer	7 88 	22	Name and Address of I				Home Maryland 2122
		23a. arti. Enter the disease, or com	/ plications that caused the	death. Do not ent					Approximate
Physician		s ck or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	STAGE			SEASE		Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co		,		30/136		
		Sequentially list conditions, harry, leading to him ediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence off:					
cuted	Examiner	that initiated events	C.						
icate be executed physicien and sithe burial-transit	Exa	resulting in death) Last	Due to (or as a co	nsequence of):					
ficate to physics the b	dical		d						
To the Hospital or Attending Physician: The law requires thet the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	23c. If yes, outcome of printing 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal déath 3 □	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
quires thet n signed b uld be deta	b	Part II. Other significent conditions of	ontributing to death but no		derlying cause given in I	Part I.			to the cause of death? Probably 4 @Unknown
law rec as bee 2 shou	Completed	CAR-DIOMY	PATHY	IS	CHEMIC		24a. Was an	24b. Were	autopsy findings available o completion of cause of
The cate has page	Com	COLITIS, J	IS CHEMI				autopsy performe 1 Yes 2	death	o completion of cause of ? es 2 No
sician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		0	Place of Death (Cr			
g Phys er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient	28c. Injury at	Nursing Home 28d.		ce 6 Other (Si	Decify)
ath. or: Afte	atlo	1		ar) Injury	Work? M 1 ☐ Yes	2 No			
tal or Attus after de sal Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, strepecify)	eet, factory, office	28f. I	Location (Stre City or Town,	et and Number or State)	Rural Route Number,
Hospit 24 hour Funeral sletely fills	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of my niner: On the basis of exa and manner stated.	/ knowledge, death mination and/or inv	occurred at the time, da estigation, in my opinion	ite and place, and o	due to the cau t the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
To ti To ti comp	Σ	29b. Signature and title of certifier			29c. License num	nber		J. Date signed (Mo	
/		1 Suni	la, mo		D302	72		5/03/2	00 6
5		30. Name and address of person who THOMMS 5.	completed cause of death		Print) ON SECA	and t	tospi	TAI	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S		- V 3 = Up	Mrs 1	10371	/ / · · ·	
Regist	rar	MAY 0 8 200	16 Jane	N. A.	W.				
HMH 17 Rev 1/	2001		,						

Registrar DHMH 17 Rev 1/2001

Physic /Medi		1. Decedent's Name (First, Middle, Richard	Last) J. Rygie	ıl Jr.			2. Date of Dea Month MAy	Day	3. Time of Dec
Exami		4a. Facility Name (If not institution,	give street and number)			own, or Location of D		4c. County of	
uneral		3004 Baybı 5. Social Security Number		ge (In yrs. last birti		ndalk Year H Under 24 I	Hrs. 8. Date of Birth	<u> </u>	
Director	4	285-46-2123	1 2 M 2□ F			Days Hours A	Jan. 3,	1949	9. Birthplace (State or Fo Country) Ohio
WOI		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City L
lined of	ctor	MD Balt	timore	Di	undalk				1 □ Yes 2
a or 28	Director	10e. Street and Number 3004 Baybi	riar Road		10f. Zip Co	ode 1222		10g. Citizen of W	hat Country?
me 23	Funerai	11. Marital Status	12. Was Decedent	t Ever in U.S.	13. Was Deceden	nt of Hispanic Origin	(Specify Yes or No-		- American Indian,
other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 【 X Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			y Cuban, M <i>e</i> xican, Pi X No <i>Specify:</i>	Jerto Hican, etc.)		White, etc. White
natu	leted	15. Decedent's (Specify only highest	s Education t grade completed)	16a.	Decedent's Usual ((Give kind of work)	Occupation done during most of retired)	working	16b. Kind of Bus	
than the	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ruchase:			Lucen	t Tech
d other	BeC	17. Father's Name (First, Middle, L	ast)		<u>r uemube</u>	18. Mother's	Nam <i>e (First, Middle,</i>)
	To	Richard J	- · · · ·				ty Rose		
27 te marke traumatic		19a. Informant's Name/Relationshi					Rural Route Number		
If item 2 or other		20a. Method of Disposition		20b. Place of cemeters	Disposition (Name	of er place)	Date		City or Town, State
Important: If eny injury or once.		1 ☐ Burial ※ ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp		Bayvi	y, crematory or other ew Crema	atory 5/	3/06	Baltimo	ore MD
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Physicia edical Exami	an/	1. Decedent's Name (First, Middl		llers					2	Date of Dear Month May 5, 20	th Day	Year		ime of Death
		4a. Facility Name (if not institution Linton Road /North bo	n, give street and nur	mber)	41	o. City, Too Sykesv		ocation of	Death	1VIQY 5, 20	4c. C	ounty of Dea	th	
Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under	1 Year		_	8. Date of Bir)/YYYY) 9. B		ce (State or
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Division of Vital Records, P.O. Box 68760, rothe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical Co	29a. Certifier 1 Certifying Pt	nysician: To the best miner: On the basis o	of my knowled	ge, death occurre				e, and d	ue to the caus	e(s) and r	manner as sta	arted	
To wit	Mec	29b. Signature and title of certifie	and manner st	ated			icense					te signed (M	onth, £	Pay, Year)
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le		Zabiullah Ali, M.D.	Assistant Medic	al Examiner	111 Penr	Street,	Baltin	ore, M	D 212	01				
S Regis	tate trar	31. Date filed (Month, Day, Year)		gistrar's Signati	ire Acce	R. P.								

DHMH 17 Rev 1/2001 OCME 2006

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	Physici /Medio			Charles	Simon						May	6,	2006		7 pm	М
	Examir	ıer	4a. Facility Name (If not institution, give str				4b. City, T					4c.	County of	Death		
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ŀ	Funeral Director		034 07 7177	/ 2□ F 7. Ag	91	Yrs.	If Under 1 Months	Days	If Under	24 Hrs. Min.	8. Date of E (Month, I NOV.	Birth Bay, Year)	9. Birthplace (State or Foreign			r Foreign
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Him	그 돈 본 분		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee		A11 C								esvil			
Ba	Depa Depa Impo any ii		Pauge Sought Of 23a. Part 1. Enter the disease, or complica	eubert		HA Sy	IGHT kesvi	FUNI 11e	ERAL"" MD	HOME 2178	& CHA 4 (410	PEL,	PA (15-140)	Box O	195)	
1	Medical Examiner	Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Chron		or):	ruct	T're	- po	In	von cor	7 0	lišæ	16	Interval Bett Onset and D	
). Box 68760,	ie death certificate be executed the attending physicien and hed for use as the burial-transit	Physician/Medical Exa	in the past 12 months?	. If yes, outcome	2 Fetal death	n 3□E	Ectopic preg Other (spec						23d. Date o		-	'ear
, P.O.	res that the de		9 ☐ Unknown Part II. Other significant conditions contri	in the und	derlying cau	use giver	n in Part I.		23e. Did	tobacco u	obacco use contribute to the cause of death?					
ords	w requires been sign should be	ted by	Atrial flutte		, ,						1/2	Yes 2 No 3 Probably 4 □Unknown				
Division of Vital Records,	The la ate has page 2	Completed	Coronary o	very	dise	ase	_					s an opsy formed? 2 \(\sum \) No	prio dea	r to com	esy findings a apletion of ca 2 No	ivailable iuse of
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	-14-4						of Death	(Check only	one)				
5	ys Sign	2	1 195 2 NO	pital: 1 Inpatie	The second second		3□ DOA	_	4 🗆 1401		ne 5 Hes			Specify,)	
ion	Attending F r death. ector: After by the funera	ation:	27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		Time of Injury	280 M	c. Injury Work 1 🗆 Y	at ? es 2⊡N		28d. Describe	how injur	y occurred			
Divis	el or Atte s after des it Directo id in by th	27. Manner of Death Selection Selecti									or Rural	Route Numb	ner,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 12 Certifying Physic 2 Medical Examine	ian: To the best of T: On the basis of and manner sta	examination an	e, death o	occurred at stigation, in	the time	o, date and nion, deat	place, a	and due to the	cause(s) , date and	and manne place, and	er as sta	ited. the cause(s)	
	To the within 2 To the Complete	Σ	29b. Signature and title of certifier	. ~				License				29d. Date	e signed (A		,	
<u></u>			N John M	N)			D	34	849			Ma	4 8	Ó	2006	
10	2		30. Name and address of person who com	pleted cause of d	eath (Item 23a)	(Type, Pr	rint)	Rd	E	ders	burg	MD	21	78	4	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 2005	32 Aegistra	ar's Signature	April	we see									

			1 - For State Registrar	State of M	farylan			nt of H <i>te of L</i>			ental Hy	ygiene Reg. No	2006	5	14393
			1. Decedent's Name (First, Middle, La	st)							2. Date of D	eath			3. Time of Death
	Physici /Medic		James Edo	rar Shi	pman						Month April	30 -	y Yes 2006	ır	1319p ^M
7	Examin		4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location of				. County of D	eath	13190
в			Washington Adve	ntist Hos	pital		Tak	oma P	ark				Montgo	mer	V
	Funeral		Social Security Number 6. S		ge (In yrs.	last birthday)	If Unde	or 1 Year Days	If Under	24 Hrs.	8. Date of B (Month, D				e (State or Foreign
	Director		234-30-0682	1 M 2 □ F	82	Yrs.	Worth	Days	Tiours	IVIII 1.	09/06/	1923	We		Virginia
	and *		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	ocation							100	Jacida Oliv III is
	Aarys reho	ŏ	VA Fairfa	×	1 '	pringf								100	Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number			F	-	ip Code				10- 0	V	2	
	with Sa or		6710 New Hope De					2151					tizen of What		
	ns 2;	era	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. \			soanic Orio	gin? (Sner	ify Yes or N		United 14. Race - A		
മ	or Her	Funeral	1 Never Married 2 Married	Armed Forces 1√2¥es 2 ☐ If Yes, Give	?		_		n, Mexican	, Puerto R	cify Yes or N Rican, etc.)		Black, W		
<u>ල</u>	al', o		3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 √ 2 No	Specify:				Specify: W	hite	9
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or Items 23a or 28a-f ehow Int, the Medicel Examinar must be notified at	Completed by	15. Decedent's E			16a. Deced	dent's Us	ual Occupa	tion	t ad dein	_	16b. K	ind of Busine	ss/Indus	stry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or	5+)			ork done d use retired)			g				
	filed w Hygien Sther th	Col	12			Air'	Traf	fic C					FAA		
Ē	tal H	Be	17. Father's Name (First, Middle, Last)								(First, Middle		Sumame)		
3	should be filed within 72 hours after death with the Marylan and Mental Hygiene. In marked other then "natural", or liems 23a or 28a-f ehow umatic event, the Medical Examinar must be notified at	မ	Paul Shipman								Armstr				
Maryland	2 8 8 2		19a. Informant's Name/Relationship (**									or Town, State		
	of Heelth item 27 other tra		Candace Shipman 20a. Method of Disposition	 Daughte 	r 20h Pi	3322- lace of Dispo	-12N	oodbu	rn Vi	llage	a Dr	Anna	ndale,	VA 2	2003
کّ	Pages nent of I int: If it		1 Burial 2 Cremation 3		Cé	вінецегу, степ	natory or	otner place	"						
altimore,	permit. Pag Department Important: eny injury c	1	4 □Donation 5 □ Other (Specification 21 Signature of Funeral Service Licer		INa	tional	-				71.7		ls Chu		VA
g	permit. Pages Department of Important: If if eny injury or c		Solution of Children Solvice and					nd Address		. De	emaine	Fun	eral K	ome	
			23a. Part1. Enter the disease, er com	olications that cause	d the death	Do not ente	308 I	de of drupa	1CK r	a, Sp	oringi	ield	, VA		on proximate
	.		shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.									l In	terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	esp	yahn uence of):	7	for,	lwr	- 5/	P	Me	chani	4	
	Examiner			C I F	s a consequ	dence of):			220	/	, Ve	ng. C	es n		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequ		1	c .	CYY	est	_				
	outed ansit	直	Cause. Enter Underlying Cause (Disease or injury that initiated events		Se	155	19								
Ď	an an rial-tı	Examine	resulting in death) Last	Due to (or as	a censequ									1	
8/PU	cate be executed physician and the burial-transit	dical		_ d	6 h	eum	e v	11 a							
٥		Med	IF FEMALE:											1	
X Q Q	death certifi e attending id for use as	an/	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic c	regnancy				4	23d. Date of d		
	the al	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of de		Other (s						Month	Da	y Year
Z.	w requires that the death certif been signed by the attending should be detached for use a	F.				Mail i									
Š	requires that een signed b	۵	Part II. Other significant conditions o	ontributing to death t	out not resu	liting in the un	iderlying	cause giver	n in Part I.						ause of death?
ecora	regu	Completed										Yes 2	NO 3□	Probabi	y 4 □Unknown
Hec	e la hes	dr.									24a. Was auto	an psy ormed?	24b. Were prior to	autopsy comple	findings available etion of cause of
	cate pag										1 Yes	ormed? 2 No	death	s 2[
VII	- 0 -	Be	25. Was case referred to medical examiner?	Hospital:						of Death	Check only	one			
5	this la	5	1 Yes 2 No	1 🖭 Inpati		ER/Outpatient			4 1140				5 □Other (Sp	ecify)	
	After Fune	<u>o</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		28c. Injury a Work?			d. Describe	how injur	y occurred		
S	Attending r death.	Cal	2 Accident investigation 3 Suicide 6 Could not be		iun. At hon		M		es 2□N		26 1	· C+ · · · ·			
DIVISION	after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of In- building, et	c. (Specify,)	et, ractor	у, опісе		20	City or To	wn, State	d Number or I)	Hurai Ho	oute Number,
	spita lours neral		29a. Certifier 1 Certifying Ph	ysicien: To the best	of my know	viedge death	OCCULLED	at the time	date and	1 place, an	d due to the	causo(s)	and mannar	a clata	-
	To the Hospital or Attent within 24 hours after death the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medical Examone)	iner: On the basis of and manner st	i examinati	ion and/or inv	estigation	, in my opi	nion, death	h occurred	at the time,	date and	place, and di	ue to the	cause(s)
	comp third	ž	29b. Signature and title of certifier				29	c. License	number			29d. Dat	e signed (Mor	nth, Day	, Year)
	Y		· DI					1)0	06	010	0	0	50,	10	6
			20. Name and address of severe vites												
2	, V		30. Name and address of person who												
2	,0		31. Date filed (Month, Pay, Year)			23a) (Type, F									

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and	Mental Hygi	4000	14394		
_			Registrar 1. Decedent's Name (First, Middle, Last)		061	tincate of	Death	2. Date of Death	g. No.	3. Time of Death		
	Physici	an	Genevieve Ann St	uni				Month May	Day Year 2006	10:30 A ^M		
	_/Medic		4a. Facility Name (If not institution, give stre	•		4h City Town o	r Location of Deat		4c. County of Deat			
	Examin	er								timore		
	Euporol		Catonsville Commo 5. Social Security Number 6. Sex	7. Age (In vrs	last birthday)	If Under 1 Year		8. Date of Birth	9. Birt	hplace (State or Foreign		
	Funeral Director		187-14-4357 ^{1□ N}	1 2EF 83	Yrs.	Months Days	Hours Min.	Jun. 29	1922 Pen	nsylvania		
	D		Usual Residence of Decedent							T		
	nylan how		10a. State 10b. County	10c. C				10d. Inside City Limits				
	Ba-fs	cto	MD Baltimo	re		Catonsvi	111e			1 Tyes 2 No		
	ith th 20 26	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?		
	ath w	ral	16 Fusting Avenue				21228		United St			
	er de	Funeral		Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit			
20	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2. No If Yes, Give Year or Dates:		1□Yes 2 No	Specify:		Specify: W	hite		
21213-0030	hour tural			15 Decedent's Education 16a Decedent's Usual Occupation								
Ċ	in 72 " na	olet	(Specify only highest grade of	ompleted)	(Give	kind of work done DO NOT use retire	during most of wo	rking	6b. Kind of Business			
7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Cashier			Grocery			
5	Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M	aiden Sumame)			
yland	ic ev	To B	Michael Seabolt				Mary 3	Jane Rober	cts			
ary	shous ind N mar umel	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State, 2	Zip Code)		
Mar	alth a		Stanley P. Stupi	Husband	4843	Carmella	Drive, H	Baltimore,	, MD 21227			
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other treumetic event, If a Madical Examiner ment be natified at ance.		20a Method of Disposition	*	Place of Dispo	sition (Name of	ce)	Date 2	0c. Location - City or	Town, State		
Ĕ	Page hent contributed int: If		1 ABurial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)		lemoria			5, 2006	Elkridge,	MD		
<u>=</u>	permit. Departn Importe any inju		21. Signature of Funeral Service Licenses	9/2	22	2. Name and Addre	ss of Facility An	nbrose Fur	neral Home	, Inc.		
מ	89 5 8 8		COM MAR NO	an HOLL	130/1	328 Sulpl	nur Sprin	ig Rd., Ai	butus, MD	21227		
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea	th. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	4	172	eimer	5 Der	montia		Onset and Death		
	/Medical		resulting in death)	Due to (or as a conse	-	111111		1000				
	Examiner		Conventially list conditions									
		ner	Sequentially list conditions, if any, leading to immediate cause. Little Industrying Cause (Disease or injury that initiated events c	Due to (or as a conse	quence of):							
	nd	Examiner	Cause (Disease or injury that initiated events c.									
/on,	ate be executed sysician and he burial-transit		resulting in death) Last	Due to (or as a conse	quence of):							
	ate b hysic the bi	lical	d									
200	eath certificat attending phy I for use as thi	Med	IF FEMALE:									
X D	death or e attend od for us	lan/	23b. Was decedent pregnant in the past 18 months?	. If yes, outcome of pregr 1☐Live birth 2☐Fet	al death 3	Ectopic pregnanc		23d. Date of del Month	livery Day Year			
- 5	the de y the a ached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5L	Other (specify)						
Ž.	that the de led by the a detached t		Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
Š,	Se 20 80	d by	HT	N		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 ☐ Yes	s 2□No 3□Pr	robably + Dinknown		
Ö	w require been si	etec						24- 146	0.45 34/2			
Hecord	e la has le 2	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of		
	Th ate pag							1□ Yes 2	1 □ Yes	2 No		
VItal	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	spital:		Ott	nor \	ath (Check only one				
ō		. To	1 Yes 22 To	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o	nt 3 DOA	wursing i	28d. Describe how	nce 6 Other (Spe winjury occurred	cify)		
sion	ding P. h. After funera	tlon	Natural 5 Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		, , , , , ,			
S	or Attending tter death. Director: After in by the fune	flca	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome, farm, str				Street and Number or Rural Route Number,			
<u> </u>	or Attence after death I Director:	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Town,	State)			
	e Hospitel or 24 hours afte e Funerel Dir etely filled in		29a. Certifier entitying Physic	ian: To the best of my kr	owledge, deat	h occurred at the ti	me, date and place	e, and due to the car	use(s) and manner as	s stated.		
	e Ho Fui	Medical	(Check only 2 Medical Examine one)	 r: On the basis of examinand manner stated. 	ation and/or in	vestigation, in my	pinion, death occi	urred at the time, da	te and place, and due	to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)		
			1 R Fernale	SHeno	line	DS	0303		2/3/6			
i	0		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type,	Print)		C .	0.0	11 2:-:2		
1			Rodolfo Fernon	der MD	405 T	redini	WRd!	ite 162	Celonsh	16,21228		
	Sta		31. Date filed (Month, Day, Year)	32 Hegistrar's Sign	ature	arte						
	Registi	rar	MAY 0 8 200	I RESIDENCE	10							

				aryland / Depa <i>Ce</i>		Health and I	Mental Hygi	•	14395			
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death			
	Physici /Medio		Thomas Earl Shifflette				May 2,	2006 Year	19:26 M			
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death	1	4c. County of Deat				
			6636 Whitmore Court Apt 153		Glen Bu			Anne Arui				
	Funeral Director		5. Social Security Number 213-36-6901 6. Sex 7. Age 1 ★ M 2 F	e (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days		8. Date of Birth April 2	Year) Q 2 Q U Co	nplace (State or Foreign untry) Virginia			
			Usual Residence of Decedent				APITI Z	1939 West	- viiginia			
	rylanc how		10a. State 10b. County		10d. Inside City Limits							
	Ba-f.s	ctol	MD Anne Arundel	Glen Burn	ie				1 ☐ Yes 2√√No			
	or 20	Dire	10e. Street and Number 6636 Whitmore Court Apt 153		10f. Zip Code			g. Citizen of What Co	untry?			
	s 23a	Funeral Director			21061			S.A.				
	fer de finer.	-un	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2₹○4*		If Yes, specify Cub	Hispanic Origin? (S) oan, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White				
036	urs al	by	3 ☐ Widowed 4 ☑Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: Whi	lte			
2-0	72 hours after death with the Maryland natural', or flems 23a or 28a-f show Jisal Exal. Art must be traffied at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Busin (Give kind of work done during most of working									
21	han a	mpi	Elementary/Secondary (0-12) College (1-4or 5-	+)		during most of worked)		ir Conditi				
Maryland 21215-0036	iled v tygiei ther t		17. Father's Name (First, Middle, Last)	Machi	nist	19 Matharla Na		anufacturi	.ng			
and	d be fantal h) Be	Carl Shifflette				ne (First, Middle, M B. Beall	alden Sumame)				
Z	should nd Me mark mark	그	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Street	1		City or Town, State, Z	in Code)			
M	alth al 27 le ir trau		Virginia B. Kemp/Mother						e MD 21228			
Jre,	ss 1 a of Hei item othe		20a. Method of Disposition	20b. Place of Dispo cemetery, crer	osition (Name of	ice)		Oc. Location - City or				
Ē	Page nent c		1 ☐ Burial 2 ☐ Scremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	West Aru	ndél Cre	matory 5/4	4/2006 0	denton, MD				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Estructural be rediffed at once.		21. Sign. ru -> of Fun. r Service Licen ee	Â	Name and Addre	ess of Facility Uneral Hor	ne. Inc.					
_	66500		JUN HE THEY	1.	328 Sulph	nur Spring	g Rd. Arb	utus MD 21	227			
П			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	θ.				it,	Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ABDO	ysin		342ens						
В	Examiner		Due to (or as a consequence of): Arterios Clerotic Disease									
		e		consequence of):	oric !	DI 36456			19 early			
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			754 nears						
o,	ate be executed hysician and the burial-transit	Exa		consequence of):					<u> </u>			
8760,	sate be executed hysician and the burial-transit	licai	d									
9	leath certifica attending ph I for use as t	Physician/Med	IF FEMALE:									
Вох	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnanc	у		23d. Date of delik	very Day Year			
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 1 9 ☐ Unknown 9 ☐ Unknown	ime or death 5 L	Other (specify) _				,			
	res that the de signed by the a i be detached f	y Ph	Part II. Other significant conditions contributing to death bu	t not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?			
Records,	quires in sign uld be	ed by	CHRONIC OBSTRUCTIVE	Wing D	Isease	,	1 20 es	2 □ No 3 □ Pro	bably 4 Unknown			
000	aw requir as been s 2 should	Completed	OLD Cerebrougscula	~ Disea	Se.		24a. Was an	24b. Were aut	opsy findings available			
	The lay	mo					autopsy performe	prior to co	ompletion of cause of			
Vita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one)	5.0	2010			
	ding Physician: The h. h. After this certificate ha funeral director, page	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatier		IL 3 DOA		ome 5 Residen	ce 6 □Other (Speci	fy)			
on c	ding F n. After funera	on	27. Manner of Death 1	(Year) 28b. Time of Injury	Wor		28d. Describe how	injury occurred				
Division of	r Attencer death	ertification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injur	ry - At home farm stre		Yes 2 □No	28f Location /Stre	et and Number or Rur	al Pauta Number			
<u>></u>	after after Direct	erti	4 Homicide determined 289. Flace of injur- building, etc.	ry - At home, farm, stre (Specify)	BOL, IACIONY, OTHOG		City or Town,	State)	ar noute warmber,			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2.	alC	29a. Certifier 1 Certifying Physician: To the best of	f my knowledge, death	occurred at the tir	me, date and place,	and due to the cau	se(s) and manner as s	stated,			
	he Ho in 24 he Fu pletel	edical	(Check only one) 2 Medical Examiner: On the basis of and manner stat	examination and/or inv	vestigation, in my o	pinion, death occur	red at the time, date	and place, and due t	o the cause(s)			
	Tot Tot com	Σ	29b. Signature and title of certifier	(29c. Licens			. Date signed (Month,	1			
,	10		> Sheveen D. Kerm	amon		138912		05/03/	OG.			
ř			30. Name and address of person who completed cause of de		Print)		0.40	05/03/				
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	Sta Registra	_	MAY 0 8 2006	1 1300	was							

			1 - For State Registrar	State	of Maryla	and / Depa <i>Ce</i>	artmen rtificate				Mental H	ygien Reg. N	2 U L	16		396
	Physici	an	1. Decedent's Name (First, Middle Paul W. Sz								2. Date of D Month April		ay DOO	Year		of Death
	/Medic		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death	ADLII			of Death	1:18	Рм
	LAGITIN		Union Hospita	1				kton					Cec			
	uneral irector	71000	5. Social Security Number 218-07-7607	6. Sex 1 X M 2 ☐ F	7. Age (In yr.	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth Day, Year	j 21	Cou	olace (State ntry) yland	e or Foreign
land	* T		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation							1	Od. Inside	City Limits
Man		ctor	MD Balt	imore		Baltim	ore								1 □ Y€	es 2 No
vith th	or 28	Funeral Director	10e. Street and Number			,	10f. Zip							What Cour	ntry?	
leath v	ns 23s	erai	6602 Kenwood A		edent Ever in	118 13		1237	coanio Ori	ain? (Ca	ooifu Vaa oo N	US			and the Con-	
:1215-0036 within 72 hours after death with the Maryland	proposition to medital and workers regions to propositions 23s or 28e-f show monotonic if them 27 is marked other than "natural," or liens 27s or 28e-f show any injury or other treumatic event, the Modical Examinar must be multihad at once.	þ	1 Never Married 2[X Marri 3 □ Widowed 4 □ Divorced	Armed F	orces? 2 🗆 Nollill ve	II	f Yes, spec		Specify:	giir (3p i, Puerto	ecify Yes or N Rican, etc.)	10-		ck, White,	can Indian, etc. ite	
25 P	natur	eted	15. Deceden (Specify only highes	's Education		16a. Dece				t of work	una .	16b. I	Kind of Bu	usiness/In	dustry	
21215-0036 34 within 72 hours aff	then to Me	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President/Founder								Beltway					
E filed	other ent,	Be Co	17. Father's Name (First, Middle,	Last)		Pre	sloen				e (First, Middle			foof:	Lng	
Variety Mente	arked atic ev	To B	Walter Szuga	j					S	tell	a W	lysoc	:ki			
Maryland d 2 should be file	7 Is m		19a. Informant's Name/Relations								Al Route Numl				Code)	
6 - and Head	tam 2		Dorothy Szugaj 20a. Method of Disposition	/Wite	20b.	Place of Dispo	Kenwo sition (Nam	od I	Ave.,		timore			nd 2	21 237	
Page:	nt: If I		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from Decify)	JUNE	cemetery, cren arkwood				5/02	/2006			lle,		
Baltimore, permit. Pages 1 ar	Importe		21. Signature of Puneral en ce			22	. Name and	d Address	s of Facility	, Ru	ck Tows son, MI	son	Fune: 1204	ral H	ome,	Inc.
*			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	caused the dea								1207		Approxima Interval Be	ate etween
	sician		Immediate Cause (Final disease or condition resulting in death)	_ a∩	nyoca	zodia	l ic	fo	xct	-					Onset and	d Death
	ledical aminer		resulting in death)	Due to	(or as a conse	equence of):)								
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	s th	edicai		d.								_				
. BOX 6 death certifi	attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr		Ectopic pre	unanev					23d. Date	e of delive	ry	
The dear	by the at tached fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of		Other (spe						Mor	nth	Day	Year
J E	00 0	V Ph	Part II. Other significant conditio	ns contributing to d	eath but not re	sulting in the un	derlying ca	use giver	n in Part I.		23e. Did	tobacco	use contr	ibute to th	e cause of	death?
Hecords, P	been sign should be	ed by	CHF									Yes 2		3 ☐ Proba		Unknown
Heco The lawre	2 5	ompieted	cardiac	histor	21						24a. Was		24b. V	Vere autor	osy findings	available
	pag	O			8						perfo	ormed?	d	leath?		cause of
OT VITAI Physicien: T	0 6	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		7500	/	Other			(Check only					
	£ =	⊢ ⊦	27. Manner of Death	28a. Date		28b. Time of		c. Injury a Work?	4 🗀 Nur.		ne 5 Resi)	
VISION Attending r death.	tor: After the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	n, Day rear)	Injury	М		s 2□N	lo						
0	el Director: ed in by the	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place	of Injury - At h	home, farm, stre lify)	et, factory,	office		2	28f. Location (City or To	Street ar wn, State	nd Numbe	er or Rural	Route Nur	n <i>ber</i> ,
To the Hospitel o	To the Funeral Direc completely filled in by	edicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the examiner: On the band man	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred a estigation, i	t the time n my opir	, date and nion, death	I place, a	and due to the ed at the time,	cause(s date and	and mar d place, a	nner as stand due to	ited. the cause(s)
To t	To t	Σ	29b. Signature and title of certifier	01	//			License				29d. Da	te signed	(Month, L	ay, Year)	
			Karen	(hel	1 YTS	D	B	L9	247	51	8		51	110	6	
101	41		30. Name and address of person	complete us	e of death (Ite	m 23a) (Type, F		ow 5	::::::::::::::::::::::::::::::::::::::	Elkti	on, Mar	rv1 ar	•			
n (1963)	Stat		31. Date filed (Month, Day, Year)	1701/EI)	gistrar's Si	ature	antil a		, .		,	. y <u></u> .		741		
The state of	Registra	ar	MAY 0 8	3 2006 🔏	MASS.	15. 169										

			For Stata Registrar	State of Mary		•	nt of Health and te of Death		iene 2006	14397
	Physici		1. Decedent's Name (First, Middle, Last)	DA MARIE	AMERI(CA SWO	PE	2. Date of Deat Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st		. 1.		, Town, or Location of Dea		4c. County of Deat	h
			5. Social Security Number 6. Sex	6 10	yrs. last birth		BULLY MONE			hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 1	м XXF 100		Months				ARYLAND
	ס		Usual Residence of Decedent	10	c. City, Town	or Logation				10d. Inside City Limits
	farylar show	ō	MD. 10a. State N/A		ic. City, Town		ALTIMORE CI	ΤY		XXYes 2 □ No
	286-1	Director	10e. Street and Number			10f. Z	p Code	1	0g. Citizen of What Co	untry?
	deeth with the Maryland ms 23s or 28s-f show rmatte rediffed at	alD	2211 WEST ROGER	S AVENUE			21209		U.S.	
6036 036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or itame 23e or 28e-f show any injury or other traumatic event, the Mudical Exercities must be rediffed at once.	by Funeral	11. Marital Status 1: 1 Never Married 2 Married XXWidowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:	rin U.S.	13. Was Dece If Yes, sp 1 \(\text{Yes}	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 2XXXNo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:	
Pe, 1	l within 72 ho iene. r then "netur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 YEARS	ation completed) College (1-4or 5+)	16a.	life. DO NOT	ork done during most of wo	orking	ENGLISH ATTAILORING	Industry AMERICAN COMPANY
(Work	ld be filed ental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) JOHN HENRY	SCHLUTER	,		18. Mother's Na	ume (First, Middle, M LIA	Maiden Sumame) FRED	ICKIA
$S \omega c$	nd 2 should alth and Men 27 is marke ir traumatic		19a. Informant's Name/Relationship (Typ	AUGHTER)	19b. 840		SS (Street and Number or F NDER ROAD, LI			
Baltimore,	Pages 1 ament of Heament: If Item		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	1	cemeten	Disposition (Na v, crematory or ND MEM			PARKVILLE,	MARYLAND
Balt	permit. Departr Importe any in		21. Signature of Funeral Service License	e (R. G. I	RUTH)		and Address of Facility TOWSON FUNER	AL HOME,I	NC. TOWSON	MD.21204
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.	death. Don		de of dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death Vears
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence o		h rom bos	ς.		Yeurs
	7 16 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	-		70111 [3.3.1			
ć	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of	t):				years
68760,	ate y	edical	d.					1.7.5		
P.O. Box	v requires that the death certificate be been signed by the attending physicia should be detached for use as the bur	Physician/Medical	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of p 1	Fetal death	3 □Ectopic 5 □ Other (s			23d. Date of del Month	ivery Day Year
	quires that in signed by uld be deta	5	Part II. Other significant conditions conf	tributing to death but n	ot resulting in	the underlying	cause given in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	
Division of Vital Records,	> 0 0	Completed						24a. Was a autops perforr 1 □ Yes	ned? / death?	ntopsy findings available completion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	a El fara		Other	eath (Check only on		
on of	ling After une	lon: To	1 Yes 2 No 10 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 (DER/Out 28b. T ear)		28c. Injury at Work? 1 Yes 2 No	· · · · · · · · · · · · · · · · · · ·	ence 6 Other (Spe ow injury occurred	ciry)
Divisio	or Atten efter deal Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, fai Specify)			28f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,
_	• Hospital 24 hours • Funeral letely filled	Medical C			amination and		d at the time, date and place, in my opinion, death occ			
	To the within 2 To the complet	Me	29b. Signature and title of dartines	NI -		2	9c. License number	2	9d. Date signed (Mont	h, Day, Year)
			mes 0	Thus	ITIA	2	DO0242	28 L	May 4	2006
	5		FIEDERICK !	mpleted cause of deat	40 2	Type, Print)	u. Belved	ere A	ve Baltin	roremo
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 8 2006	3. Registrar's	A A	book				

DHMH 17 Rev 1/2001

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	1		State of Maryland		t of He	alth and M	fental Hygie		LOG.	11.300
Physicial /Medica Examine	n il -	1. Decedent's Name (First, Middle, Last) ATHERINE 4a. Facility Name (If not institution, give str	1 1 1	110-11	IK.	ocation of Death	2. Date of Death Month	- 1	Year 2006 ty of Death	2=08 AM
Funeral Director		5. Social Security Number 6. Sex 214.14.2274 Usual Residence of Decedent	7. Age (In yrs. I	dast birthday) If Under Months Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y AUG 30, 1	'ear)	9. Birthpl Count	ace (State or Foreign ry) MD
death with the Maryland	Director	10a. State 10b. County MD ANNE ARUN 10e. Street and Number		N BURNIE	. Code		100	g. Citizen o	f What Count	od. Inside City Limits 1 Yes 2 No XX
3 0 a # #	by Funeral D	7865 AMERICANA CR. 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	#102 2. Was Decedent Ever in U. Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates:			anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		USA ace - America ack, While, e	etc.
21215-00 21215-00 ed within 72 hou ygiene. ner then "nature it, the Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	al Occupations done during retired)		ring	мотог	MARYL	CLE ADMIN.
laryland 2 should be fill and Mental H is marked oth	To Be	17. Father's Name (First, Middle, Last) OSCAR JOHNSON 19a. Informant's Name/Relationship (Type	e, Print) HUSBAND	19b. Mailing Addres	T s (Street and	HELMA A	ral Route Number,	City or Tow	n, State, Zip	
Lity and Pa		ALBERT THYR 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Place of Disposition (Na emetery, crematory or VIEW CREMAT	me of other place) FORY	5.8.	Date 20 2006 E	Oc. Location	ORE N	wn, State
Baltim Permit. Pa Deperment important any injury any injury		21. Signature of Funeral Service Licensee K GREGORY FINK 23a. Part. Tee the disease of con plic shock, of seart lailure list on one Immediate Cause (Final	MO114	8 426 CI	RAIN H	of Facility L HOME, WY SW G	LEN BURNI	Ε, <u>Μ</u> Γ	21061	Approximate Interval Between Onset and Death
Medical Examiner personned portal-transit prival-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence of t	uence of):	teg	Lise	04 ··			
BOX death cer e attendir	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıl death 3 ⊟Ectopic p					Date of delive Month	ory Day Year
ecords, P.O. law requires that the nas been signed by the s 2 should be detache	Completed by PI	Part II. Other significant conditions cont	tributing to death but not res	ulting in the underlying	cause given	in Part I.	1 ☐ Yes 24a. Was an autopsy	2 □ No	3 Prob	ably 4 JUnknown psy findings available mpletion of cause of
on of Vital Recding Physician: The faw h. After this certificate has I funeral director, page 2 s	To Be	1 Yes 2 No		ER/Outpatient 3 C	Other	4 🗆 Nursing H	perform 1 Yes 2 th Check only one ome 5 Resider 28d. Describe how	ØNo nce 6 □0		
Division of Vital Records, to Attending Physician: The law requires tatler death. Director: After this certificate has been signed in by the funeral director, page 2 should be e	Certification:	27. Mano of of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specia	Injury M ome, larm, street, lacto	Work?	es 2 🗆 No		eet and Nu		Il Route Number,
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		inism: To the best of my kinism: To the basis of examina and manner stated.	ation and/or investigation		nion, death occu	rred at the time, da	te and plac		the cause(s)
6		30. Name and address of person o cor	DOIL	m 23a) (Type, Print)) ;)	3638 U GL	EN BUR	8/-	N/66	21061
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature M. Acast	1					

DHMH 17 Rev 1/2001

		_ For	State of Ma									o n	02	1100
		1 - State Registrar			Cei	rtificate	of De	eath			Reg. No.	40	Ub	1439
Dhueic		1. Decedent's Name (First, Middle, Last)			111 -	ط ماد		2.	Date of De Month	ath Day	Yea		e of Death
Physic /Med			mothy			WYI	grii			May	4	200		CO M
Exami	ner	4a. Facility Name (If not institution, give		امدد		4b. City, To			13.		4c.	County of De	eath	
		The Johns Hopk 5. Social Security Number 6. Se			ast birthday)	If Under 1	HMC	f Under 24	CITY Hrs. A	Date of Bird	th	9. F	lirthplace (Sta	ate or Foreign
Funera Director			XM 2□ F 7. A9	62	Yrs.				Min.	Date of Bird (Month, Da 7/03/1			country)	ato or r or org. r
		Usual Residence of Decedent								7037	1745	TIC		
rylan		10a. State 10b. County		10c. City	, Town or Lo	cation							,	le City Limits Yes 2 ☐ No
Ba-f s	Director	Maryland			Balti							(117)		163 2 10
with the		10e. Street and Number				10f. Zip C		0.5				zen of What	Country?	
s 23g	ral	516 North Clinton		Ever in U	S 13 1	Was Decede	2120		n? (Specify	Yes or No	U.S		nerican India	n.
ter de	Funeral	11. Marital Status 1 □ Never Married 2 🕅 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢			Was Deceder			Puerto Ric	an, etc.)		Black, W		
0036 hours after death with the Maryland turat' or items 23a or 28a-f show al Examiner must be multibut at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 [XNo S	Specify:			Ì	Specify: B	Lack	
5-0	Completed	15. Decedent's Ede (Specify only highest grad	ucation #		(Give	dent's Usual kind of work	done duri	on ing most o	of working		16b. Ki	nd of Busine	ss/Industry	
thin ithin	n dr	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use	,							
d 21215- filed within 72 Hygiene. other than "nal		17. Father's Name (First, Middle, Last)	4		Chu	rch Pa		B. Mother's	s Name (F	irst, Middle,		iniste: Sumame)	r	
and the following the follows of or or or or or or or or or or or or or	Be	Elmer Wright								Go1d:				
Maryland 21215-0036 d 2 should be filed within 72 hours al' th and Mental Hygiene. 77 is marked other than "naturat, or traumatic event, the Medical Exam	2	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address (r Town, State	, Zip Code)	
ore, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be nutified at		Patricia Wright /	Wife		3502	Glenar	m Av	enue,	, Bal	timor	e, M	arylan	d 2120	6
or the item		20a. Method of Disposition	2	20b. P	lace of Dispo	sition (Name	of er place)		Date		20c. Lc	cation - City	or Town, Stat	ө
Pages nent of nnt: If it		1 🕅 Burial 2 ☐ Cremation 3 ☐ I `4 ☐ Donation 5 ☐ Other (Specify)			ng M e mo	orial	Park		5/11/2				, Mary	
Baltimore, Misperial Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licens	•		1								F/H,	
m & 5 = 5 5		1	7/2									ce, Ma	ryland Approx	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each li	the death ne.	n. Do not ent	ter the mode	of dying, s	such as ca	ardiac or re	spiratory a	rrest,		Interval	Between and Death
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BO path c	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3[Ectopic pred						Month	Day	Year
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that	by Pt	Part II. Other significant conditions co	ontributing to death b	ut not res	ulting in the u	nderlying cau	use given i	in Part I.		23e. Did t	obacco u	ise contribute	to the cause	of death?
cords, P w requires that been signed to should be dete	ed b									1 🗆 '	Yes 2	₹ No 3□	Probably 4	Unknown
aw re	Completed									24a. Was	DSV	prior t	o completion	ngs available of cause of
Rec The lav	Com									perfo	med?	death	7	
Vital Records, sician: The law requires to certificate has been signer rector, page 2 should be or	Be (25. Was case referred to medical examiner?							of Death (C	check only o	one)			
of V Physic this c	2	1 Yes 2 No	Hospital: 1 XInpatio		ER/Outpatier			4 🗀 14013		5 🗌 Resi		6 Other (S	oecify)	
Sing Fall	lon:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	M 200	c. Injury at Work?	s 2 □ N		. Describe	now injui	y occurred		
Division of Vital Records, P.O. Box 68 for Attending Physician: The law requires that the death cartifica after death. Director: After this certificate has been signed by the attending ph in by the funeral director, page 2 should be detached for use as the fine by the funeral director, page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 2 should be detached for use as the first page 3.	lical	3 ☐ Suicide 6 ☐ Could not be	289. Place of In	ury - At ho	ome, farm, st								Rural Route	Number,
Div after Dire	Certification:	4 Homicide	building, et	c. (Specif	y)					City or To	wn, State)		
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	/sician: To the best iner: On the basis of	of my kno	wledge, deat	h occurred at	t the time,	date and	place, and	I due to the	cause(s)	and manner	as stated.	se(s)
the Ho in 24 the Fu	Medical	one)	and manner st						100001100	at 110 time,				
To the To the complet	Σ	29b. Signature and title of certifier	madie	100	rtor		Oa s		00				onth, Day, Ye	
1		Anu Gupta					KKO	-01	00		Ma	44	, 200	16
6		30. Name and address of person who a	completed cause of c	eath (Iten	n 23a) (Type, Soù∔∧1 .	Print)	Joceth	WOLF	e Sec	et.a	altim	we Mar	ulant:	21287
	tate	31. Date filed (Month, Per, Year) 20	32 Registr	ar's Signa	ature A	2001		0001	-0111		est (35.3 f)	or Chiron	- bearing	
Regis		MATU & ZU	100 Jan	Sing of	The Party	NO THE REAL PROPERTY.								

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / [ment of H		nd Men		ene 0)6	14400
	Physici	an	Decedent's Name (First, Middle Robert							Date of Death Wonth y 2, 20	OPAX.	Year	3. Time of Death
	/Medie Examir	al	4a. Facility Name (If not institution			4b	. City, Town, or	Location of		y 2, 20	4c. County	of Death	8:08 р м
E	Examili	ier	Franklin Squar				Rosed		Doain			ltimo	re
	Funeral Director		5. Social Security Number 149-28-0302	6. Sex 7. A	ge (In yrs. last bir 67		Under 1 Year onths Days	If Under 24 Hours	Min. De	Dale of Birth Month, Day, Y C 28,	1938	Cour	lace (State or Foreign htry) Jersey
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location	on					1	0d. Inside City Limits
	e Man ta-f sh	ctor	MD	Baltimore	Perr	y Hal	1						1 Yes 2 No
	with th	Director	10e. Street and Number 4110 Westmeath	n Poad		1	Of, Zip Code 212:	36		10g	. Citizen of W		•
	death me 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of His s, specify Cubar		in? (Specify	Yes or No-		S.A.	an Indian,
21215-0036	nit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hyglene. ortant: If item 27 is marked other than "natural", or Iteme 23e or 28e-f show injury or other traumatic event, the Medical Examination institled at 1.2 in the Medical Examination of 1.2 inclined at 1.2.	by	1 Never Married 2 Mar 3 Widowed 4 Divorced		⁷ ^{No} '60-'66		s, specify Cubar Yes 2XNo	Specify:	Puerto Rica	n, etc.)	Specify:	c, White, Whi	
15-0	"natu	letec		it's Education st grade completed)	16a.	Decedent'	s Usuaf Occupa f of work done di NOT use retired)	tion uring most o	of working	16	b. Kind of Bu	siness/Ind	dustry
212	within jiene.	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+	5+)		rance Sa			L	.ife Ir	sura	nce
nd	be filed stal Hygi of other event, t	Bec	17. Father's Name (First, Middle,							st, Middle, Ma			
Maryland	should the should the	은	Robert 19a. Informant's Name/Relations	W. Yoos	106	Maille A			rie			rtin	
	l end 2 sho feath and im 27 is m		Patricia A. Yo		41	L10 W	estmeath		, Balt	imore,	MD 21	236	
Baltimore,	permit. Pages 1 end 2 Department of Health s Important: If item 27 th any injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 € Cremation 4 ☐ Donation 5 ☐ Other (S	(pecify)		p Sei	ry or other place ry Corp		Date 5/8/06		Towson	, MD	
Balt	permit. Depart Import any inj		21. Signature of Funda a Service	Cicensee Willian	i G. Dau		me and Address 50 York				Funera 21204	1 Ho	me, Inc.
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each I	d the death. Do r		_	1.	1	1		/	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	s -wh	1000	cscu		30134	•	o years
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89	artifical ing phy e as th	Medi	IF FEMALE:										
D. Box	that the death certifics ed by the attending pt detached for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		opic pregnancy eer (specify)				23d. Date Mon		ry Day Year
P.O.	that the	Phy	Part II. Other significant condition	ons contributing to death b	ut not resulting in	the under	ying cause giver	n in Part f.		23e. Did tobac	cco use contri	bute to th	e cause of death?
rds	w requires that been signed b should be deta	ed by								1 🗆 Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknown
Division of Vital Records,	4 4	Completed				<u> </u>			_	24a. Was an autopsy performed I Yes 21	d2 de	ior to con	osy findings available inpletion of cause of
/ital	cian: ertifice ector.	Be	25. Was case referred to medica examiner?							eck only one)	(10)		2.54.110
o	Attending Physician: r death. ector: Atter this certifice by the funeral director. I	- T	Yes 2 No 27. Manner of Death	Hospital: 1 Inpation			DOA Other	4 🗆 19015		5 Residence)
on	nding ath. r: After e fune	atlon	1 Natural 5 Pendin 2 Accident investig	g (Month, Da	y Year) In	fury	28c. Injury Work? 4 1 □ Y	es 2 □ No		Describe now	anjury occurre	iu	
Divis	el or Attendi s after death il Director: A id in by the fu	Certification:	3 Suicide 6 Could determ	ined 286. Place of In	ury - At home, far c. (Specify)	m, street, f	factory, office		28f. L	ocation (Stree City or Town, S	et and Numbe State)	r or Rura	Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	edical (29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best Examiner: On the basis o and manner st	f examination and	, death occ	urred at the time gation, in my opi	a, date and nion, death	place, and d occurred at	ue to the caus the time, date	se(s) and man and place, ar	ner as stand due to	ated. the cause(s)
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			- In-	M) Ne	Puty			66		M	ay 3	, 2C	006
15	5+1		So. Name and address of person	who completed cause of c	leath (flem 23k) (Type, Print	H:11C	71.4	hen			210	93
1	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	Spar	W	11,5-W.					- 0

		For State Registrar	State of Maryland		rtment of H tificate of I		d Mental Hy	giene Reg. No.	006	14402
Physicia		1. Decedent's Name (First, Middle, Last, Catherine Alburti					2. Date of De Month April	Day	2006	3. Time of Death 1625
/Medica Examine Funeral Director		4a. Facility Name (If not institution, give SCCZED HEAD. 5. Social Security Number 6. Sec.	street and number) T (OSPita		4b. City, Town, or Months Days	Location of De OL (OL If Under 24 H Hours M	inth	th	County of Death	QNUX place (Sale or Foreign ntry)
Maryland f ehow	Jo.	Usual Residence of Decedent		, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the a or 28a-	Direct	10e. Street and Number		berlan	10f. Zip Code				en of What Cou	intry?
be filed within 72 hours after death with the Maryland hall Hygiene. Id other then "nature!, or Iteme 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral Director	556 Jane Frazier 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	j	21502 Yas Decedent of H Yes, specify Cuba Yes 2 No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Ameri Black, White,	, etc.
Mary fallor & L. 1.3-00.00 d.2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other then "naturel", or traumatic event, the Madical Exam traumatic event.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decede (Give k life. D	ent's Usual Occupind of work done of NOT use retired	ation during most of v	working		whited of Business/Ir Home	
d be filed ental Hyg ked othe c event,	To Be C	17. Father's Name (First, Middle, Last) John E. Sherry	,				Name (First, Middle	, Maiden S	Sumame)	
re, Maryland	F	19a. Informant's Name/Relationship (Ty Sacred Heart Hosp			·	and Number or	Rural Route Numb			p Code)
permit. Pages 1 end 2 Department of Health Importent: if Item 27 any Injury or other tr.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. PI	ace of Dispos	eton Dr1 ition (Name of atory or other place		perland,		502 ation - City or T	own, State
permit. Departrimporte any inju		21. Signature of Funeral Service Licens Fonald S.	Wade Director	St	Name and Address ate Anat ltimore,	omy Boa	rd 655 W	. Bal	timore	Street
Physician /Medical Examiner	-	23a. Parti. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	ne cause on each line.	ence of):	r the mode of dyin		liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
cate be	dical Examiner	Sequentially list conditions. I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
that the death certificate by the attending detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → ₩0 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□I	Ectopic pregnancy Other (specify)			23	3d. Date of deliv Month	ery Day Year
w requires that the been signed by should be deta	ed by Ph	Part II. Other significant conditions con	ntributing to death but not resu	liting in the un	derlying cause givi	en in Part I.		obacco us Yes 2		the cause of death?
	Completed	OF the constant to make the					1 ☐ Yes	psy ormed? 2 ☐ No	24b. Were autoprior to codeath?	opsy findings available impletion of cause of
Physicies this certi	To Be	1 162 2 10		ER/Outpatient		er: 4 🗆 Nursing	Death Check only	dence 6		fy)
t or Attending Physical Color of the Color o	atlon	27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1 1	/at ⟨? Yes 2 ☐ No	28d. Describe	how injury	occurred	
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifici completaly filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre)	et, factory, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
To the Hospital or within 24 hours after to the Funeral Dir completaly filled in	Medical	29a. Certifier 1. Certifying Phyone) 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the tine	ne, date and pla pinion, death of	ace, and due to the courred at the time,	cause(s) a date and p	and manner as solace, and due to	stated. o the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	leni h D.		29c. Licenso	1565		29d. Date	signed (Month,	Day, Year) 2006
Stat Registra		30. Name and address of person who or Anthony Bollin 31. Date filed Month Day, Year 1006	ompleted cause of death (Item 32. Registrar's Simat	Natio	mal H	ighwa	y Lal	lale,	MDS	21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AFRIL **Physician** 27. 2006 4:55 PM Francis Andersen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 11, 191 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 18 M 2□ F 1911 Mary1and Director 213-05-4292 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "naturel", or iteme 23a or 28a-f ehor the Madical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Pikesville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4115 Old Milford Road Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Deportment of Health and Mental Hygiene. Important: if Item 27 ie markad othar than "na any injury or othar traumatic event, the Modil once." unk unk Elementary/Secondary (0-12) College (1-4or 5+) 8 none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jens Christian Andersen Rosa Lenz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephany A. Wright/daughter 102 Elmhurst Road Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility menald S. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RUPTURE OF ABDOMINAL AORTIC ANEURYSM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical ettending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. he 9 Unknown 9 Unknown Š been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 A No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours er To the Funeral C completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mella

DHMH 17 Rev 1/2001

State

Registrar

D41410

7601 OSLER DRIVE TOWSON MARYLAND

m.O

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHTA.M.D.

10 344

TOGINDER P.

MAY 0 9 2006

31. Date filed (Month, Day, Year)

APRIL

27

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10e per 11, 8355 5-16-06 vt

State of Matyland / Department of Health and Mental Hygiene

Amend Item 1 per doc 835 5-26 vt

Reg. No. 2 0 0 6 1 - For State Registrer Reg. No.C. 1. Decedent's Name (First, Middle, Last) Michael A. Abbott St. 2. Date of Death Year **Physician** Month 10: 23 PM nunael 2006 **Mali** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Schns Hopkins Bayview Melical Center Baltimare
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of 1 6. Sex 1 △ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min. Hours 217-94-7758 Yrs. 40 Director 10-8-1965 Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Hygiene. other then "neturel", or items 23e or 28a-f show ent, tra Modical Examinar must be notified at 1 Tyes 2 No MD Directo Baltimore City 106 6) and Number 10f. Zip Code 10g. Citizen of What Country? 50 Erdman Avenue 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Wo Specify: þ Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Insulator 12 Union Local #24 f Health and Mental Hygie Item 27 is marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be John R. Abbott, Sr. Margaret Wickham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i Baltimore, MD 21219 2400 Oak Manor Road, John Abbott, Sr. Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State permit. Page Depertment o Importent: If eny injury or once. Bayview Crematory 5-9-06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facilit Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licenses Birthet PA, 2134 Willow Spring Rd., 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HUPO XIC KES Kesquatern week /Medical Examiner P515 week Securations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examine physician end s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 ☐ Yes Ken 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2: autopsy 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Margatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be To the Hospital or Attention 24 hours efter de To the Funerel Director completely filled in by the 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time. date and clace, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Resident 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfe tact Baltimer Maryland 21787 Victoria Udden 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Men 15 MAY 0 9 2006 Registrar

Bohnslar, Carol Jean

			Please	Type or Print in I	Black Ind	lelible Ink.	Ensure All	Copies	Are Legible	
			1 = For State Registrar	State of Marylar		rtment of H tificate of L		ental Hy	giene 00	5 14405
			Decedent's Name (First, Middle, L.)	.ast)				2. Date of De	aath	3. Time of Death
	Physicia /Medic		Carol Jean Bohu	ıs1av				Month	7 200	6 12,55AM
	Examin		4a. Facility Name (If not institution, g	ive street and number)		0.	Location of Death	,	4c. County of De	ath 1
			10 110 1	shington Medi		If Under 1 Year		Dono of Di	Hnne 1	trundel
	Funeral Director			7. Age (In yrs.	Yrs.	Months Days	Hours Min.	B. Date of Bir (Month, Di	ay, Year)	lirthplace (State or Foreign Country) MD
			220-42-6809 Usual Residence of Decedent	02			L L	rec z,	1943	FID
	ehow		10a. State 10b. County	10c. Ci	ity, Town or Loc	ation				10d. Inside City Limits
	Ba-f e	cto	MD Anne Ar	undel S	evern	T				1 ☐ Yes ¾(¬¬No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code	,		10g. Citizen of What	•
	eath v	erai	782 Elmhurst Rd	12. Was Decedent Ever in U	J.S. 13. W	2114	4 ispanic Origin? (Spec	ifv Yes or N	US 0- 14. Race - Ar	nerican Indian,
10	r item	Fun	1 ☐ Never Married → Married	Armed Forces?	If	Yes, specify Cuba	n, Mexican, Puerto R	ican, etc.)	Black, Wi	hite, etc.
8	rai', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 🔏 🖟 No	Specify:		Specify: Wh	nite
5-0	72 h natu	etec	15. Decedent's (Specify only highest of		(Give I	ent's Usual Occupa kind of work done of	furing most of working	g	16b. Kind of Busines	ss/Industry
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		hogo Adm	, <u>inistrator</u>		NSA	
	filed Hygir other	Be Co	17. Father's Name (First, Middle, La	st)	Data	base Aum	18. Mother's Name			
<u>a</u>	fental rked ricev	To B	Elmer L. Sisk	-			Imogene A	1exan	der	
Maryland	ges 1 end 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship						er, City or Town, State	, Zip Code)
	end 2 ealth m 27		Louis Earl Bohus				Rd Severr		21144	
Baltimore,	Pages 1 nent of H int: if Ite		20a. Method of Disposition 1 Maio Burial 2 ☐ Cremation 3	☐Removal from State		atory or other plac	θ)		20c. Location - City	
Ϊ	it. Pa		4 □Donation 5 □Other (Special Service Lice			1 Cemete)6	Baltimore,	MD
Ba	permit. Pages 1 end 2 Depertment of Health a Important; if Item 27 is eny injury or other tre ance.					nk Funor	al Home I	A		1061
			R. Gregory F. 23a. Part Enter the disease, or coshock, or heart failure. List on	emplications that caused the dea	th. Do not ente	or the mode of dying	HWY S G.I g, such as cardiac or	en Bu:	rnie, MD - 2 arrest,	2 1 0 6 1 Approximate Interval Between
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	Examiner		Sequentially flat conditions	b. Ilented	alle	000000	Can			
.7	bed isit	xaminer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence or):					
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68	ntifical ng ph as th	Medi	IF FEMALE:							I
Box	ith cei Itendii or use	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 🗌	Ectopic pregnancy			23d. Date of o	delivery Day Year
0.	D 00 D	ysici	1 Yes 2 No	4 Pregnant at time of 9 Unknown	death 5□	Other (specify)				,
۵.	requires thet the de teen signed by the a hould be detached f	Completed by Physician/Medical	Part II. Other significant conditions	s contributing to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Division of Vital Records,	8 5 8	d b						1 🗆	Yes 2 □No 3 □	Probably 4 Unknown
20		oiete						24a. Was	s an 24b. Were	autopsy findings available
R	The law cete hes b pege 2 si	mo:						perf	ormed? prior t death 2 No 1 Y	
ita	iclan: Th certificete ector, peg	Be	25. Was case referred medical examiner?				26. Place of Death	(Check only	one)	
<u>5</u>	Physic this o	P	1 Yes 2 No		ER/Outpatient		4 Hursing Hon		idence 6 Other (S	pecify)
n C	ding F	ion:	27. Manuar of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	yat k? Yes 2 □ No	sa. Describe	how injury occurred	
/isi	Attender deat	fica	3 ☐ Suicide 6 ☐ Could not	t be 28e. Place of Injury - At I	nome, farm, stre				(Street and Number or	Rural Route Number,
ă	s efter	Certification:	4 Homicide	building, etc. (Spec	ity)			City or 10	iwn, State)	
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edicai (Physician: To the best of my kn						
	the hin 24 the F	Medi	one)	and manner stated.		A 29c. License			29d. Date signed (Mo	
	5 in 50	-	29b. Signature and title of certifier	E Wills	WIT	D 290 D 4	1365		May 9	2006
	1		30 Name and address of parent in	no completed cause of death (lite	da 23a) (Tune I	Print)	1 1 5		1157	D 10121
	2		30. Neme and address of person when the state of the stat	JICKS TO	D. 30	1 X-05p-A	tal Driva	G.	on Burnie	, MD 2106/
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature day	de s				
	Regist	ar	MAY 0 9 20	006	· Marie	6				

			For Stata Registrar	State of Marylar		ent of Health ate of Death		giene Reg. No:	006	14406
7	Dhi-i		1. Decedent's Name (First, Middle, La.	(1)			2. Date of D	eath Day	Year	3. Time of Death
4	Physici /Medic		Mary Vi		njamin		May	Ole	2006	7:25 AM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location			ounty of Death	
-	Funeral		5. Social Security Number 6. S	Y And IV COUCE ox 7. Age (In yrs.			r 24 Hrs. R. Date of B	rth	9. Birthp	lace (State or Foreign
S4,	Director		212-46-6654	□M X □F 57	Yrs. Mont	hs Days Hours	Min. (Month, D	1948 <u>1948</u>	Mary	Tand
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ity, Town or Location				1	0d. Inside City Limits
	Maryli f eho	tor	Maryland N/A		Baltim	ore				1X Yes 2 No
	r 28e	Directo	10e. Street and Number			Zip Code		10g. Citize	n of What Cour	ntry?
	23a c		1416 West Pr	att Street		21223		US.	Α	
36	be filed within 72 hours after death with the Maryland at a Hygiene. Ide Hygiene. Ide Andre then "natural", or items 23a or 28e-f show other then "natural", or items 23a or 28e-f show event, the Madical Examinar must be notified a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		ecedent of Hispanic Or specify Cuban, Mexica s 2 No Specify	rigin? (Specify Yes or N an, Puerto Rican, etc.) v:		Race - Americ Black, White, pecify:	
21215-0036	2 hou	ted	15. Decedent's Ed	lucation	16a. Decedent's U	Isual Occupation	and and considering	16b. Kind	of Business/In	
215	thin 7	Completed	(Specify only highest gra	College (1-4or 5+)	life. DO NO	work done during mo T use retired)	ist or working			
	filed wi Hygien Sther th	Con	5 17. Father's Name (First, Middle, Last)	0	Home	maker	ner's Name (First, Middle		n Home	
Maryland	e d is b ≥	To Be	Johnny	Marcum			Mary Hite	e, Maideil St	imame)	
ary	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is marke any njury or other traumatic once.	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Street and Numb	ber or Rural Route Numi	ber, City or T	own, State, Zip	Code)
	and 2 lealth a m 27 is	٠,	Kenneth J. Nuckle				e., Baltimo			
ore	Pages 1 nent of H int: If ites iry or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	Place of Disposition (cemetery, crematory	or other place)	Date		tion - City or To	
Baltimore,	pernit. Page Department of Important: If any injury or once.	. 33	4 Donation 5 Other (Specifical Secretary of Europe Licer		dar Hill C	emetery t	5/10/2006	Balt	imore,	Mary land
Ba	Department of the partment of		21. Signature of Funeral Service Licer	*** Kevin E Eck	McCul 237 F	ly-Polynia Patansco	k Funeral I Ave., Bal	lome,	P.A. 21	.225-1856
Ü,	£		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not enter the r	node of dying, such a	s cardiac or respiratory	arrest,		Approximate Interval Between
i V	Physician		fmmediate Cause (Final disease or condition	, brain	nernia	tion				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					21 112 -
~	A	er	Sequentially list conditions if any, leading to immediate	b. Due to (or as a consec		ema			-	JU TWWS
J	outed Nd ansit	Examiner	Cause (Disease or injury that initiated events	C.						
Ö,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	cate be executed physician and the burial-transit	dicai		. d.					-	
9 X		0	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn				230	d. Date of delive	erv.
. Box	0 0	Physician/M	in the past 12 months?	1 Live birth 2 Fet		c pregnancy (specify)			Month	Day Year
о. О	res that the de signed by the a be detached f	hys	9 □ Unknown	9□ Unknown						
ś	The law requires that the ste has been signed by thi bage 2 should be detache	þ	Part II. Other significent conditions of		sulting in the underlyir	ng cause given in Part		tobacco use Yes 2□I		ne cause of death?
Ö	w require been si should I	eted	right to is	(OI)						
Records,	has law	Completed						s an opsy formed?	prior to co death?	psy findings available mpletion of cause of
Vital	ifficate or, pa	e Co	25. Was case referred to medical			26 Plac	1 ☐ Yes se of Death (Check only	2 No	1 🗆 Yes	21 X No
>	ysicie is cert direct	OB	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other	lursing Home 5 Res		Other (Specif	iy)
0	ding Physician: The I h. After this certificate ha funeral director, page	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date _f Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury o	occurred	
Division of	tendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b	9	М	1 ☐ Yes 2 ☐		(0)		
$\overline{\mathbf{S}}$	after of Direction by	Certification;	4 Homicide determined	28e. Pface of Injury - At h building, etc. (Speci	nome, tarm, street, tac ify)	ctory, office		(Street and r own, State)	vum <i>ber</i> or Hure	l Route Number,
_	To the Hospitel or Attending Physician: within 24 hours after dear to the Funeral Director: After this certification plants in the funeral director, completely filled in by the funeral director,		29a. Certifier Certifying Ph	ysician: To the best of my kn	owledge, death occur	red at the time, date a	and place, and due to the	cause(s) ar	nd manner as s	tated.
	the Hin 24 the Fu	Medical	One)	niner: On the basis of examinand manner stated.	ation and/or investiga					
	with To Con	2	29b. Signature and title of certifier	MO.		29c. License number	C/L		signed (Month,	
	1		30 Namo and address of succession	- NCOX M	m 22a) /Tuna Driet	7196	000	MAY	06	2006
	9		30. Name and address of person who	22 Sowth	Greene	St Pril	timore, N	11) 2	1201	
	Sta		31. Date filed (Month, Pay, Year)	32. Registrar's Sign		l a				

DHMH 17 Rev 1/2001

06-02976 Gavin Burks

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Javiii Duiks	1- For State Certificate of Death Reg No. 2 0 0 0 0 1 1 1	0
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 4.500	U
- Carliner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
·	10900 Coastal Highway Apt 101 Ocean City Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	
Funeral Director	149-36-1917 The state of the st	a
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
Maryland 28a-f show 1 at once. ector	Maryland Worcester Ocean City 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No
h the Maryland 3a or 28a-f sh otified at onco	10e. Street and Number 10900 Coastal Highway, Unit 101 10f. Zip Code USA 10g. Citizen of What Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 3 Widowed 4 X Divorced of Pates: 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Yes 2 X No specify: 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. 11. Race - American Indian, 8lack, White, etc. 10. Yes 2 X No specify: 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
hours a	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
5-0036 ed within 72 hour tygiene. other than "natt the Medical Exat Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Carpenter Carpentry	
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE COMPIE	Richard W. Burks Mary K. Townsend	
MD 21 dd 2 should ulth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Ocean Parkway, Ocean Pines, Md. 21811	
Baltimore, MD Openit. Pages I and 2 sho Openitent of Health and Important: If item 27 is injury or other traumati	20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Bayview Crematory, Inc. 5/6/06 Baltimore, Maryland	d
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Signature of Funeral Home, P.A.	
	130 E. Fort Ave., Baltimore, Md. 21230 234. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inter	val
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a Head Injuries Between Onset a Death	
, Annual Control	or condition resulting in death) Due to (or as a consequence of): b.	
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ox 68 sth certif attending or use as	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (Specify)	
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Records, P.O. I The law requires that the ficate has been signed by the page 2 should be detache Completed by PP	autopsy performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
tal Recian: The certificat	25. Was case referred to medical 25. Place of Death (Check only one)	
f Vit. Physici er this c ral dire	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other Scene	
ion o tending eath for: Afte the fune		
Division of Vital Records, P.O. spiral or Attending Physician: The law requires that the hours after death. ueral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P.	3 Suicide 6 Could not be determined (Specify) Found at home 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State) 10900 Coastal Highway Apt 101, Ocean City,	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Corr		
F S F S	4 × 4 × × × × × × × × × × × × × × × × ×	
7+1	30. Name and address of person who completed cause of death (Item 23a)	
/	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
State Registra	MAY O O COCO	
DHMH 17 Rev 1/2001	ORIGINAL	

			For State Registrar		State of Ma	aryland / I	Depar <i>Certi</i>	tment of H ificate of I	ealth and Death	d Mental	Hygiei Reg.		16	14408
	Physici	20	Decedent's Name (F.		•					2. Date of	of Death	Day	Year	3. Time of Death
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¥	Examin	er			it Avenue	9	'	,,	arkvil					imore
F	uneral		5. Social Security Numb		Sex 7. Ag	e (In yrs. last bi		If Under 1 Year Months Days	If Under 24 H Hours Mi		of Birth		9. Birtho	lace (State or Foreign
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nyland	Mon T	_		b. County	14:	10c. City, Tow			_				1	Od. Inside City Limits
the Ma	28a-f	Director	MD 10e. Street and Numbe		ltimore		Pa	rkvill	e 		100	Citizen of W	hat Cour	1X Yes 2 □ No
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ing, mallylating 2.12.10-000 Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.	item 27 is marked other then "neturel", or items 23s or 28s-f show other treumstic event, the Medical Examinat must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Decedent Armed Forces? 1 XYes 2 1 Yes, Give Year or Dates:			as Decedent of H /es, specify Cuba	ispanic Origin? n, Mexican, Put Specify:	(Specify Yes of erto Rican, etc	or No-		c, White,	an Indian, etc. White
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filed	other t	0	12 17. Father's Name (Firs	st, Middle, Las	<u>4</u>			CHEMIS	18. Mother's N	lame (First, Mi	iddle, Maid			
uld be Mental	rked tic ev	To B	Alexan	nder Ba	lakir				Frances	Gawlik				
12 sho	reum.		19a. Informant's Name Barbara Ba				-	Address (Street a						
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it. Pages	rtant: If njury or		1 ☐ Burial 2 💢 C 4 ☐ Donation 5 ☐ 21. Signature of Funera	Other (Speci	·-	Evans	Fune	eral Cha Pair Name and Addres	œl 5-	9-06	For	rest H	ill,	Maryland
Depa	eny ir		Emolo	1.17	1= tendel	_	880	00 Harfo	ed Road-	vans Ch Parkvi	apel lle.	Of Me Marvl	mori and	es 21234
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the death ce	To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?	23c. If yes, outcome 1□Live birth 4□ Pregnant at 9□ Unknown	2 Fetal death		ctopic pregnancy Other (specify)			_	23d. Date Mon		ory Day Year
o, r	gned b	by Pl	Part II. Other significar	nt conditions	contributing to death b	ut not resulting	in the und	erlying cause give	en in Part I.	23е.	Did tobacc	o use contri	bute to th	ne cause of death?
require	een sig									-	1 Tes	2 🗆 No	3 Prob	ably 4 □Unknown
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ician:	ector,	Be	25. Was case referred examiner?	to medical	Hospital:			3 DOA Oth	25	eath (Check o	1			
2 5	or this oral dia	10	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date of Inju	ry 28b.	Time of	3 DOA 28c. Injun	4 LI NUISING	Home 5 28d. Desc		6 Othe		y)
ath.	or: Afte	atio	2 Accident	Pending investigation		(Year)	Injury		<br Yes 2 □ No					
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• Hospit	e Funeraletely fills	Medical	29a. Certifier 12 (Check only 2 one)	Certifying P Medical Exa	hysician: To the best miner: On the basis of and manner sta	examination at	e, death o	occurred at the tin stigation, in my o	ne, date and pla pinion, death oc	ace, and due to courred at the t	the cause ime, date	e(s) and mar and place, a	nner as si nd due to	ated. the cause(s)
To tf withir	To the comp	Ň	29b. Signature and title	of certifier	3.16	Ph		29c. Licens	o 392	97	29d.	Date signed		
14	11		30. Name and address MICha	. /	completed cause of d	eath (Item 23a)	(Type, Pr	rint)			1			2/23x
	Sta Registr		31. Date filed (Month, L	Day, Year)	32 Registr	MO ar's Signature	Sie	W.	50/1/	in 1 4		self.	1-(1)	-163/
			P41/1		And Calledon		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 2 per doc 2856 (Department of Health and Mental Hygiene) | | | | 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAYnth Dav **Physician** 12.40pm CHESTER CASE BALDWIN 2006 acci /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MERCY RIDGE HEALTH CARE CENTER Timonium

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**∑** M 2□ F 88 215-12-7596 Usual Residence of Dece Director Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County raf', or Itama 23a or 28a-f ahow Exeminer cust be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road, S-713 21093 e filed within 72 hours after death val Hygiene. USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Private Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental Hisant: If itam 27 is marked oti John Cook Baldwin Ada Harriet Case 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road, S713; Timonium, Mp 21093 and Disposition (Name of 200. Location - City or Town, State <u>Maria A. Baldwin</u> (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 9, 2006 Baltimore, Maryland Friends Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Me of Fundal S. N. Licen ee Martin D. Lawson 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. awson Martin D. Lawson

6500 York Road, Baltimore, Maryland

21212

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Lather and L Immediate Cause (Final Physician onnes disease or condition resulting in death) /Medical Due to (or as a const uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cete has been signed by the page 2 should be detached detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2. No 1 Yes Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖎 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May SNITES M. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) who 2300 Dulane Mestine 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

DOWN .

32. Registrar's Signature

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		•	For State Registrar	State	of Marylan		artment rtificate			and M		giene	006	Merco cana a de de de de de de de de de de de de de	
	Physicia	an.	1. Decedent's Name (First, Middle,								2. Date of Dea Month	Day	Year	3. Time of [
	/Medic	al	Richard James B 4a. Facility Name (If not institution,		umbor)		4h Cih, T	`aum ar	Location o	of Dooth	May	7,	2006 nty of Death	7:30	P ^M
)	Examin	er	11829 Farmland		amo a r)			kvi.		/ Dealis			ntgome	rv	
	Funeral	1	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day			lace (State or	Foreign
V.	Director		579-30-0758	1⊠M 2□F	77	Yrs.	I VIOTILITS	Duyu	110010		January 1	, 1929	Mic	higan	
	land	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							0d. Inside City	y Limits
	Mary	ţ	Maryland Mont	gomery		Rockvi	11e							1 🗌 Yes	2 ∑ No
	or 28	Director	10e. Street and Number				10f. Zip (of What Coul	•	
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	fter de	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Armed F			_			, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, White,		
3	ral', o	5	3 Widowed 4 Divorced	If Yes, G Year or	Dates: Kore	ea	1 ☐ Yes 2	⊠ No	Specify:			Spe	ocity: Wha	Lte	
7	tied within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23a or 28a-f ehow ent, Ite Medical Examinar must be notified at	Completed	15. Decedent (Specify only highest	s Education grade completed)	16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa	ition <i>uring</i> most	t of worki	ng	16b. Kind o	f Business/In	dustry	
7	withir ene. then	dwo	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		ess Ow					Coffe	ee Sal	es	
פ	be filed within 72 hours after death with the Marylan at Hygione. All Hygione. All Hygione. Bearingt must be notified at event, the Madical Examinat must be notified at	BeC	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden Sun	rame)		
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Ē	Pages ent of nt: If I		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Mon	tgomery	Cremato	orium	IncM	ay 9	, 2006	Bethes	da, Ma	aryland	1
Baltimore, Maryland 21215-0036	permit. Pages 'Department of H Important: If Ite any Injury or of		21. Signature of Funeral Service)	icensee	2 _{MO}	1433 Be	2. Name and thesd	a-Ch	s of Facility evy ([arv1	yRobe Chase and	ert A. 1 e. Inc. 20814-35	Pumphr 7557 501	ey Fur Wiscor	eral H sin Av	ome/ enue
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ita I	clan: ertifica ector,	Bec	25. Was case referred to medical examiner?					100		of Death	(Check only o	ne)			
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	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	A					number				gned (Month,	Day, Year)	
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DHMH 17 Rev 1/2001

		•	For State	State of Maryla		artment of F			ene2006	
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	/Medic Examin		4a. Facility Name (If not institution,		C. D C	4b. City, Town, o	r Location of Death		4c. County of Deat	1
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	Funeral			6. Sep 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birtt	nplace (State or Foreign
	Director		212-56-2478		58 Yrs.	Months Days	Hours Min.	Jan 1, 1	948 Virg	ginia
	D >		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	postion				10d. Inside City Limits
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	lter d	Š	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Forces?	0.3.	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White	
336	ors of	À	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: wh	ite
Ö	n 72 hours efter deeth with the Marylan "naturel", or Items 23s or 28s-1 show edical Examinar must be notified at		15. Decedent		16a. Dece	dent's Usual Occup	pation	16	b. Kind of Business/	
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Х		၉	Melvin J. Burde				Elsie Bo	-		
Jar	C1 C0 - C0		19a. Informant's Name/Relationsh		.11				City or Town, State, Z	ip Code)
2	1 end Health em 27 ther tr		Brandy Burdette			iverside		sadena, M		Town Chair
20			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation			matory or other place		Date 20	c. Location - City or	Town, State
Ë	Pa tent: jury		4 Donation 5 ☐ Other (Sp				1			
Baltimore,	permit. Page Depertment of Importent: If any Injury or once.		21. Signature Funeral Service L Ronald S	icensee S. Wade Dixecto	\mathbf{r}_{1} S	2. Name and Addre tate Anat	comy Board	1 655 W. I	Baltimore	Street
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Вох	death certifica attending ph d for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		-			23d. Date of deli	very
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æ	The lay ate has page 2	E						performe	d? death? No 1 ☐ Yes	2 No
ita		Se C	25. Was case referred to medical			1471 A	26. Place of Deal	th (Check only one)	4	-
*	G 15 78	ToB	examiner? 1 🗆 Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ott	ner: 4 Nursing Ho	ome 5 Residen	ce 6 Other (Spec	cify)
n of	ding Ph h. After th funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	ry at rk?	28d. Describe how	injury occurred	
Si	Attending r death. sctor: After by the fune	atic	2 ☐ Accident investig	ation		M 1 🗆	Yes 2□No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		home, farm, st	reet, factory, office		28f Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	29a. Certifier 12 Certifying (Check only 2 Medical E	g Physician: To the best of my kr Examiner: On the basis of examinand manner stated,	nowledge, deat nation and/or in	h occurred at the till vestigation, in my o	me, date and place, opinion, death occur	red at the time, date	se(s) and manner as and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	010	4	29c. Licens			I. Date signed (Monti	
	⊢≰⊢ŏ		micha	wy some	Wa	w D	21	438	Hpril	302006
			30. Name and address of person	who completed cause of death fits	m 23a) (Tvne	Print)	1	1 7 0	//-	
			MICHAELJ	LareNYAN	W) 4	45 DE1	FENSE	HIGH W	Ay FINN.	302006 AALO MDZIYON
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	The same				
	Registr	ar	MAY 0 9 2	205	She did not be a second					

sp. Toytome

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Bear No. 2006 44 2
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia		Eugene Budahazy Month Day Year April 29 2006 00:25 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
1	LAdilliii	CI	St. Agnes Healthcare Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country)
	Director		213-26-6519 75 Yrs. Jan 4, 1931 unk
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary	tor	MD Anne Arundel Pasadena 1□Yes 2⊠No
	th with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	th with	ai D	313 Hospital Drive 21122 USA
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No unk 1 Yes 2 No unk 1 Yes 2 No unk 1 Yes 2 No Specify: Spec
Ş	hour fural		15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
15	nin 72 n "ne	piet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired) unk
212	d with giene er the	Completed	unk unk
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exameter must be coulded.	To Be (17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk
Mary	d 2 shou th and M 7 is mar traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Hospital 900 Caton Ave. Baltimore, MD 21229
6	1 and Healt tam 2		20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
μ	8 = = 6		1 □ Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state
量	permit. Par Departmen Important: any injury once.		21. Signification of Funeral Service Licensee 22. Name and Address of Facility
ä	permi Depa Impo any ir		Ronald Sy Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition pulmonary embolism
7	/Medical Examiner		Due to (or as a consequence of):
	ZXXIIIII	7	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):
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Ć.	te be executed ysician and e burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):
760,	eath certificate be executed attending physician and for use as the burial-transit	cai	d
Box 68	ntifica ng ph	Med	IF FEMALE:
Š	ath ce ttendi	an/	23b. Was decedent pregnant 1
P.O. I	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Medi	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)
	that the de led by the detached	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ત્રું rds	quires n sign ald be	Q P	<u>Chronic Obstructive lung disease</u> 1 → Yes 2 No 3 → Probably 4 → Unknown
3 03	law requires as been sign 2 should be	piet	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Eugene Vital Records,	The lav	Completed	performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
ita	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?
) to	ding Physician: After this certific funeral director,	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
37	Attending Physician: r death. sctor: After this certifice by the funeral director, p	ion	27. Manner of Peath 1 X Natural 5 Pending (Month, Day Year) 1 X Natural investigation 28a. Time of Injury 28b. Time of Work? 1 Yes 2 No
ha3 vision	or Attendiate death Director: A	fical	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
(a)	를 를 들	Certification:	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)
Budaha	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th within To th comp	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			350 m MD / (931) April 29, 2006
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 M. 7 e xin 900 Caton Avenue, Baltimore, MD 21229
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Regist	rar	MAY 0 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 9.11.12.15.16a-b.17-20c per fh 88.6 6-2-06 vt State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician April 29, 2006 6:36 Cynthia Boxley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Center Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 28, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🛱 F 1958 Director 578-78-8619 48 D.C. Usual Residence of Decedent the Maryland 10h. County 10c. City, Town or Location 10d. toside City Limits 10a State 28a-fehow item 27 ie marked other then "natural", or items 23a or 28a-1 ebov other traumatic event, the Medical Examiter must be rightlied at 1 Yes 2 No Director District Heights Forestville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 20747 7420 Marlboro Pike USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unle unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene Important: If item 27 is marked eny injury or other to another. **Home** Elementary/Secondary (0-12) College (1-4or 5+) _Domestic Unemployed unk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk unk Helen V. Jackson Charles L. Boxley Sr. ဥ 19h Mailing Address (Street and Nymber of Bural Route Nymber, City of Town, State Zin Code)
2103 Woodberry St. Hyattsville, Md. 20787
7503 Surratts Rd. Clinton, HB 21735 19a. Informant's Name/Relationship (Type, Print)
Rence Boxley Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state Metro Fnr1 Svcs 5-8-06 Alexandria, Va 22. Name and Address of Facility **Snowden**State Anatomy Board (7)
Reltimere, 3D 21291 246 Funeral Home 20850 21. Signature of Funeral Service Licensee Ronald S. Wade, Dir. Wash St. Rockville. mon 11 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Cardro mys pathe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner nding physicien and use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy etter for u Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ned by the e P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 hes autopsy performed 2 No 2 No 1 Yes certificate 25. Was case referred to medical examiner? director, 26. Place of Death Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 2 1. Yes 2 🕟 No 1 Inpatient this 28b. Time of Injury After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manper of Death Certification: Attending 1 Natural 2 Accident 5 Pending To the needs after death.

To the Funeral Director: After the funeral bits of the fune 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and ting of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10055120 Wahington De 20032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Just 310

Richard Palmer 1328 Southern avenue SE

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State of Maryland / Department of Health a	nd Mental Hygiene 🕕

		1 - For State Registrar	State of Maryla	nd / Dep		leaith and Me	ental Hyg	0.0757	The state of the s
Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Las JACQUBLINE) 4a. Facility Name (If not institution, give					2. Date of Death		6 12:43 AM
Funeral Director		5. Social Security Number 216-68-4709 Usual Residence of Decedent	7. Age gh yn	s. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 2-9-1	9. Bi	rthplace (State or Foreign country) MD
iges 1 and 2 should be filed within 72 hours after deeth with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	ector	10a. State 10b. County MD Baltime 10e. Street and Number		City, Town or L inda1k			10	Og. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
r deeth with tems 23a or ar must be	Funeral Director	2605 Plainfiel	12. Was Decedent Ever in Armed Forces?	U.S. 13	21222	dispanic Origin? (Specan, Mexican, Puerto F		USA 14. Race - Arr Black, Wh	erican Indian,
2 hours afte atural, or it	þ	Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed	1 Yes 2 No If Yes, Give Year or Dates:	16a Dec	1 ☐ Yes 2 💆 No	Specify:		Specify: W	hite
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uld be filed Mental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name Jacquel		Maiden Surmarne) ee Baker	
and 2 showed and 1 mall and 1 mal		19a. Informant's Name/Relationship (7 Michael Baker	- Son	19	05 Ewa1d	and Number or Rural		24 1	
rate B		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature #1)Funeral Service Licen	B	ayvie	ematory or other pla w Cremat	ory 5-8-	·06 E	Baltimor	e, MD
permit, Departr Imports any nice.		DETALLAR		P	A. 2134	Willow S	pring	Road. 2	neral Home,
Physician /Medical Examiner		23a. Part1. Enter the disease, or companion, shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. SEVERE Due to (or as a conse	equence of):	PS15		Tospiratory arre		Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse						
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ysicla ysicla is certi	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpation	ent 3 DOA	26. Place of Death ner: 4 \(\text{Nursing Horn} \)		e) ince 6 □Other(Sp	ecify)
nding Ph th. :: After th e funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat 2 rk? Yes 2 ☐ No	8d. Describe ho	w injury occurred	
at or Atters after deg	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		street, factory, office	2	8f. Location (St. City or Town	reet and Number or I , State)	Rural Route Number,
he Hospiti in 24 hours he Funera pletely fille	edlcal	29a. Certifier 1 (Check only one) (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea nation and/or	ath occurred at the ti investigation, in my o	me, date and place, a opinion, death occurre	nd due to the ca	use(s) and manner at and de	as stated. ue to the cause(s)
To t Withi Com	Σ	29b. Signature and title of certifier	atter.	ND	29c. Licens	55 - 000	29	9d. Date signed (Moi	nth, Day, Year)
5		30. Name and address of person who of HARI NATHAN	completed cause of death (It		STREET	BALTIN	ORE	MD 21	287
S	tate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	Inature	2131)				

	1		partment of Health and Mertificate of Death	Reg. No.	Z 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Physicia	ın	Donald F. Bogdan	ski	Month Day April 3	80, 2006 8:30 p. M
/Medic Examin	-	a. Facility Name (If not institution, give street and number) 10596 Spotted Horse Lane		olumbia	County of Death Howard
Funeral Director		5. Social Security Number 6. Say 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreig Country)
		Jauel Residence of Decedent 10a. State 10b. County 10c. City, Town or		July 4, 196	10d. Inside City Limit
or 28a-f e notifi	Director	Maryland Howard 10e. Street and Number	Columbia 101. Zip Code	10g. Cit	izen of What Country?
I all to 2 solution on the control of the control o	ra -	10.596 Spotted Horse Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married It Yes, Give	21044 3. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify:
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od oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam		A. Katalinas
marke umaric	2	Donald F. Bogdanski 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Rur		
permit. Frages I and Z Department of Health a Important: if Item 27 is eny injury or other tra once.		1 Seurial 2 □ Cremation 3 □ Removal from State	rematory or other place)	Date 20c. L 5/05/2006	ocation - City or Town, State Silver Spring, Maryland
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() St	ate	30. Name and address of person who completed cause of death (Itym 23a) (Tym	2/86/ Dorsey	Hall	Ellicottaty M

ORIGINAL

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	xamin	×	4a. Facility Name (If not institution, give	ING ROAD		Burtons				nery County
	ineral rector		5. Social Security Number 214-82-6813 Usual Residence of Decedent	D14 00 C	79 Yrs.	Months Day		Ain. Aug. 03	1926	9. Birthplace (State or Foreign Country) Maryland
Manyland	f show	tor	10a. State 10b. County Md . Montgom	ery Co.	10c. City, Town or L	ocation	9			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	3a or 28a st be rottl	i Director	10e. Street and Number 4307 Sandy Sprin			10f. Zip Code	20866		10g. Citizen of Wh	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	el, or iteme 2 Examiner mus	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☆ Widowed 4 ☐ Divorced	12. Was Decedent E Amed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Đates:		Was Decedent of If Yes, specify Co	uban, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)		- American Indian, , White, etc. white
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, Mary and 2 shou	n 27 le ma er trauma		19a Informant's Name/Relationship (7		on) 801	ing Address <i>(Str</i> e 4 Tower	et and Number of Bridge D	r Rural Route Numberive, Pas	adena, Mo	d • 21122
Baltimore, permit. Pages 1 ar Department of Hea	ant: If iten ury or oth	200	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disp cemetery, cre George W	ematory or other p		06/06		ille, Md.
Balt permit. Departr	Importa eny inju pnce.		21. Signature of Funeral Service Licen 23a. Page Enter the disease, or com-	102	1.	2. Name and Add McCu11	v-Polvni	ak Funera Road, Pas	1 Home P adena, M	.A. d. 21122
	sician	8 9	Immediate Cause (Final disease or condition	one cause on each im	the death. Do not ene.				rrest,	Approximate Interval Between Onset and Death
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	6		30. Name and address of person who	15, NO 11125 PV	scientific Phi	ROCKUI W	, mo 10814			
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			1 - For State Registrar	State of Mary		tificate o			og. No. 006	14417
			Decedent's Name (First, Middle, Last	st)				2. Date of Deat Month	h	3. Time of Death
	Physici /Medio		Fern A. Carter					MAY	Son Soc	6 4:45A. M
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	yland now		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
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	and 2 sh alth and 127 is n er traum	. !	19a. Informant's Name/Relationship (1 Mrs. Gail Vesely	• • • • • • • • • • • • • • • • • • • •			eetand Number or A Lo Place		City or Town, State, Ce, N.C. 282	
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other	place) 5	Date	20c. Location - City o	
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Division of Vital Records,	i Difte	Certification:	3 Suicide 6 Could not be determined		At home, farm, stre	eet, factory, offi	се	28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical C	29a. Certifier (Check only one) (Check only one)	ysician: To the best of m niner: On the basis of exa	amination and/or inv	occurred at the	e time, date and plac ny opinion, death occ	e, and due to the ca urred at the time, da	iuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	vithin ; o tha omple	Me		and manner stated		29c. Lic	ense number	25	9d. Date signed (Mon	th, Day, Year)
	->		8n	uste M!	D	DOC	53150		4 Ay 50	2000
	3		30. Name and address of person who	ompleted cause of death	(Item 23a) (Type,	Print)		5	SUITEI	,0
			5hakunm	ALA GUI	PTA 9	650	SANTIF	140 RC	OAD CO.	WMB,A
	Sta Registr		29b. Signature and title of certifier 87 30. Name and address of person who of the two numbers of person who of the two numbers of person who of the two numbers of two numbers of the two numbers of two numbers of the two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of two numbers of	32. Registrar's	Signature	Jarles.			M	04045

			1 - For State Registrar	State of M	aryland		artment o ertificate	f Health and of Death	Menta	al Hygien Reg. N		14418
La.	Dhysioi	an	1. Decedent's Name (First, Middle,	Last)	_					te of Death	ay Year	3. Time of Death
	Physici /Medio		AMES	Michael C	_otte	R			m	MY 5	2006	
	Examin	er	4a. Facility Name (If not institution, 2303 Shore	1			0 .	n, or Location of Dea	ath		c. County of Dea HAR FORD	
F	uneral			6. Sex 7. Ac	je (In yrs. la	ast birthday	Il Under 1 Ye			te of Birth	9. Bir	thplace (State or Foreign
	irector		011-32-7522	1 X M 2□ F	63	Yrs.	Months Da	ys Hours Mir	Dec	onth, Day, Yea.	2 M	ountry) \
and	A 11		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
Mary	유명	tor	Maryland Harfo	rd	Bel	Air						1 ☐ Yes 2 No
th the	or 284	Director	10e. Street and Number				10f. Zip Coo			10g. C	itizen of What C	·
death with the Maryland	8 23a		2303 Shoreham C					014			US	
G Z I Z I 3-UU30 filed within 72 hours after de Hydiana	fried 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	?	5. 13.	Was Decedent If Yes, specify (ol Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	(Specify Ye arto Rican,	etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
72 hc	neta General	etec	15. Decedent's (Specify only highest	Education grade completed)		(Giv	edent's Usual Oc	ne during most of w	rorking	16b.	Kind of Business	/Industry
within	than	Completed	Elementary/Secondary (0-12)	College (1-4or:	5+)		DO NOT use re ical Res	/		Dh	armaceut	-ical
	other.	0	17. Father's Name (First, Middle, L	-		CLIII	icai nes	18. Mother's N	ame (First,			LCar
Should be	rked tic ev	To B	James Q. Cotte	er				There	esa G	Colli	ns	
4 2 d d d	27 is mer		19a. Informant's Name/Relationshi Kathleen Brogows					eetand Number or F Drive, H				Zip Code) 07733
Pages 1 a	Important: if item 2 any injury or other		20a. Method of Disposition 1 ☐∯urial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		СӨ	metery, cre	osition (Name o. ematory or other se Cemet	place)	Date 7 10,		Location - City or Medfield	
	Importa any inju		21. Sanature of Funeral Service L		1 0 11	2	2. Name and Ad	Idress of Facility			TOUT TOTO	.,
O 88	8 2 3		23a. Part1. Enter the disease, or o	maskew	unt		viccomas 1317 Cok	Funeral H esbury Ro	one, ad, <i>I</i>	P.A. Wbingdo	n, Maryl	and 21009
		7	SHOCK, OF HEAR FAILURE. LIST O	omplications that caused nly one cause on each li	d the death.	. Do not er	iter the mode of	dying, such ās cardii	ac or respi	ratory arrest,	_	Approximate Interval Between Onset and Death
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	a. <u>GASTA</u> Due to (or as			OCARC	INOMA				1 month
	aminer			META	STAT	7C. (POLON	ADENOC	ARCI.	NOMA		6 1000 545
V 10	.=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence ol):	,,,,,	<u></u>				
Gecute	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	ence oil):						
ooroo,	sicien buria			d								
dificati	ng phy as the	Aedical										
ath ce	ttendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal	death 3	⊒Ectopic pregna				23d. Date of de	livery Day Year
Je de	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	ath 5	Other (specify)			Worter	Say Tour
that i	deta	by Ph	Part II. Other significant condition	s contributing to death b	out not resu	Iting in the	underlying cause	given in Part I.	23	e. Did tobacco	use contribute to	o the cause of death?
requires 1	en sign									1 ☐ Yes	No 3□P	robably 4 Unknown
a v s	as be	Completed							24	a. Was an autopsy	24b. Were a	utopsy lindings available completion of cause of
r eg	cate h	Con							1	performed? Yes 202 N	death?	s 2□ No
VIC	certif	Be c	25. Was case relerred to medical examiner? 1 Yes 2 No	Hospital:		-D/O		26. Place of De				
2 4	er this	n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time	III 3LI DOA	4 Nursing		Residence escribe how inju	6 ☐Other (Speury occurred	icity)
andin E	or: Aft he fun	atlo	1 Natural 5 Pending 2 Accident investiga	ition	y rear)	Injury		work? I∐Yes 2∐No				
al or Att	i Directo	Certification	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Inj building, et			reet, factory, off	СӨ		cation (Street a y or Town, Sta		ural Route Number,
Me Hospit	To the Funeral Director. After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only one) Certifying	Physician: To the best xaminer: On the basis o and manner st	f examination	/ledge, dea on and/or in	th occurred at th	e time, date and place by opinion, death occ	ce, and due	e to the cause(se time, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
To th	To th	Σ	29b. Signature and title of certifier	7/1/	//			ense number			ate signed (Mont	
	1		Mahmel	Juntono	AM	0	0-	3355/		M	Ay 7,	2006
	15		30. Name and address of person w MICHAEL FILERS 31. Date liled (Month, Day, Year)	ho completed cause of d BACH, 9110	Phil	23a) (Type ADE/	Print) DHIA!	PD #314	. Br	/timos	ex, Mb	21237
	Sta Registr	- 60		9 2006 32. Restate	ar's Signati	TLO TO	Carle					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:551M ohn 2006 Cher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltihore C. FIMOL Bon 0-5017 ecour. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State of Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1X M 2 □ F Yrs. 1919 Director 218-14-9165 86 14 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 25 S HAWTHORNE RD 21220 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 11 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK δ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE 8th grade MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked o any injury or other traumatic eve WILLIE CHERRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Tanya McDonald/Daughter 25 S. Hawthorne Rd., Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS MEMORIAL 05-11-06 MIDDLE RIVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Value 1 12 00 W NORTH AVENUE

2411. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only gree cause on each line. Interval Between Onset and Death mmediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner tehs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 9 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Records, P.O. Box 68760, Division of Vital To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: Atter this certitica completely tilled in by the funeral

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 0 9 2006

9

3 🗍 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and tiple of

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Son Secous

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

			1 For	State of Maryland	Department of I		6	1000	14420
			Registrar 1. Decedent's Name (First, Middle, Las	"	derinicate of		Reg. No Date of Death		3. Time of Death
	Physici /Medio		Geraldine	- Cunnin	gham		Month Da	2006	1130Am
	Examin		4a. Facility Name (If not institution, give	1 1		or Location of Death) 4 _E	County of Death	
	Funeral		5. Social Security Number 6. Se		birthday) If Under 1 Year	If Under 24 Hrs. 8.	Date of Righ	9. Birth	place (State or Foreign
I	Director		XX8-20 0101	M 250F	Yrs. Months Days	Hours Min.	(Month, Day, Year)	25 11	rginia
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location		/		10d. Inside City Limits
	a-feh	ctor	na	VIA	Batter	noie			1 Yas 2 No
	with th	Director	10e. Street and Number	cia Ap	10f. Zip Code	220	10g. Cit	tizen of What Cou	ntry?
	me 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Specif	y Yes or No-	14. Race - Ameri	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or Iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cub	san, Mexican, Puerto Ric	can, etc.)	Specify: P	lach
2-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation 10 de completed)	6a. Decedent's Usual Occu (Give kind of work done	during most of working	16b. K	ind of Business/Ir	ndustry
121	within ene. then	Junc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	(1)0)	1	tospita	als
מק	buld be filed Mental Hygi arked other atic event, I	Be C	17. Father's Name (First, Middle, Last)	/ /		18. Mother's Name (F	irst, Middle, Maiden	Sumame)	
aryland	2 should b and Menta le marked aumatic e	To	Silad Mc	Reever		tda		1210	
≥	1 and 2 sho Health and Iem 27 Iem		1 A. Informant's Name/Relationship (7	ype, Print) Son	19b. Mailing Address (Street	. O N.			p Code) 1, nd, 21/33
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	e of Disposition (Name of etery, crematory or other pla	ريكا السير السين		ocation - City or T	own, State
Ħ	permit. Pag Department Important: I any Injury o		4 □ Denation 5 □ Other (Specify 21. Signature of Funeral Service Licens		22. Name and Addre	acry	i G	IMINIU	C Pra.
Ba	permit. Departr Importe any Inju		Marecum 7	1.00,001		wallace	F. Sow.	Back,	md. 21229
			23a. Part1. Enter the nisease, or comp s ock, or heart tollure. List only	lication. That caused the death. Done cause on each line.	The second secon				Approximate Interval Between
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Box	The law requires that the death certificate be executed ete has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 □Ectopic pregnanc	у		23d. Date of deliv Month	rery Day Year
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He He	he law e has l	Completed				· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performed?	death?	opsy findings available ompletion of cause of
Vital	ysician: The lis certificete hadirector, page	Be Co	25. Was case referred to medical			26. Place of Death (C	1 ☐ Yes 2 ☑ No Check only one	1 ☐ Yes	2,⊠ No
	Physic this ce al dire	မ	TE Tes ZIZINO		Conpanierii 3 DOA		5 ☐ Residence		fy)
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NISI VISI	Atten or deat octor: by the	Iffica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)			Location (Street ar City or Town, State	nd Number or Rur	al Route Number,
	Itel or ars efter ral Dir iled in							·	
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	To the within To the Compl	Me	29b. Signature and title of certifier	1.11	29c. Licens		29d. Da	ite signed (Month,	Day, Year)
)	7		Christine Ka	Jun Hospita	alist 62	412	Ma	48	2006
	10		30. Name and address of person who g	bmpleted cause of death (Item 23	(Type, Print)	and Ray	ndalla	town	Maryland
4	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		CORULTINAL	1014112	1000111	4 17114
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		State of Maryland / Department / Department / Department / Department / Department / Department		lental Hygiene	6 14421
/Me	sician edical miner	Duane A. Croslin Sr.	4b. City, Town, or Location of Death	2. Date of Death	
Fune Direct		5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1218-64-0484 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 04-18-1954	9. Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23a or 28a-f show	ector	10a. State 10b. County 10c. City, Town or Loc	Baltimore	10g. Citizen of W	10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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21215-0036 21215-0036 d within 72 hours after gleine. er than 'natural', or tte	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	ent's Usual Occupation kind of work done during most of work O NOT use retired) HVAC		Black
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Baltimore, Mary permit. Pages 1 and 2 sho Department of Health and Important: If tem 271 is mush injury or other traum any injury or other traum.		Naomi M. Knox/ Friend 20a. Method of Disposition 1		Baltimore,MD 21217	State, Zip Code) City or Town, State
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Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Fe/Outpatient	3 DOA Other: 4 Nursing Hol 28c. Injury at Work? M 1 Yes 2 No	n (Check only one) me 5 Residence 6 Othe 28d. Describe how injury occurre	od
DIVI: Hospitel or Ati 4 hours after d Funeral Direct	cal Certif	29a. Certifier (Check only Check only (Check ccurred at the time, date and place.	28f. Location (Street and Number City or Town, State) and due to the cause(s) and maneral at the time, date and place, a	nner as stated.	
To the H within 24 To the F complete	Medical	I GIVED PO	29c. License number		(Month, Day, Year)
	State istrar	30. Name an ad ress of person who completed cause of death (Item 23a) (Type, F Jensey Long Long Long Long Long Long Long Long	of Blhnore	1570)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician May 4, 2006 11:00 A M Laurel H. Crossett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson
|er 1 Year | If Under 24 Hrs. | S | Days | Hours | Min. | Baltimore Gilchrist Hospice Center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Yrs **Director** 212-20-0204 81 March 1,1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other then "neturel", or items 23a or 28a-f show event, the Mudical Exercities in the notified at 1 ☐ Yes 2 ₹ No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7405 St. Patricia Ct. U.S.A. 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Ď 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if Item 27 is marked other then *! eny injury or other traumatic event, tra Mag 402e. Elementary/Secondary (0-12) College (1-4or 5+) 12th. Grade Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Foreman Harry A. Isabel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Yorkway MD 21222 Lauray M. Deitz/Daughter Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/06/2006 Metro Crematory Baltimore 22. Name and Address of Facility
Charles S. Zeiler & Son, Inc.
6224 Eastern Avenue Baltimore 21. Signature of Funeral Service Licensee MD 21224 23a. Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bstructive Lung disense Physician RAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine and Il-transit The law requires that the death certificate be executed physician are the burial-t Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Artery disense congestive 1 10 1es 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 10 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 ☐ No After this c funeral dire 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death.

To the Funerat Director: A completely filled in by the fu death. 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)25205 MAY 4, 2006 Ken who completed aus of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET TOWSON MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

9 2006

CONCE

32. Registrar's Signature

			For State Registrar	State of Ma	ryland		artmeni rtificate					giene	006	Why and the second seco	23
			Decedent's Name (First, Middle, Last)								2. Date of Dea	ath		3. Time of	Death
	Physici		Charles Francis D	eVaughn							Month May	Bay	2006	9:50	РМ
	/Medic Examin		4a. Facility Name (If not institution, give s 963 Arncliffe Roa				,.	Town, or SeX	Location	of Death	•		County of Deat Baltimo		
Ī	Funeral Director		220 20 9013	7. Age 7. Age 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7.		as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day April 2	n 0,19.	9. Birt Co Mar	hplace (State of untry) Yland	or Foreign
	and *	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	Maryli	tor	Maryland Baltimor	1	,	Ess									2 ⊠ No
	with the a or 28a be notifi	Direc	10e. Street and Number 963 Arncliffe Rd.				10f. Zip	Code 1221				10g. Citiz	en of What Co USA	untry?	
	10 ath	era		12. Was Decedent Ev	er in U.	S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Spe	cify Yes or No	- 1	4. Race - Ame		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Bany injury or other traumatic event, the Madical Examinar must be notified a sonce.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	, MM	TT	1 Yes, spec		Specify:		Rican, etc.)	5	Black, Whit Specify: V	_{e, etc.} 7hite	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade			16a. Dece	kind of woi	rk done a	luring mos	t of worki	ng	16b. Kin	d of Business/	Industry	
21215-0036	d within piene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	<i>DO NOT</i> us Labor	e retired,)			Ste	el Mil	1	
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			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the cause on each line	he death	n. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet Onset and	tween
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/ita	Physician: r this certifici ral director, I	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
	Physic this o	မ	TE Tes 2X No	lospital: 1 ☐ Inpatien					4 🗆 191		ne 5X Resid			cify)	
u o o	Attending F r death. ector: After by the funera	ation:	27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	M 2	8c. Injury Work 1 □ `	rat ⟨? Yes 2□		28d. Describe f	now injury	occurred		
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	within To the	Me	29b. Signature and title of certifier	/ . 4 .			290	. License	number	9		29d. Date	signed (Mont	h, Dey, Year)	
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			For State	State of Maryland			Mental Hy	giene	16	11.1.21.
			- State Registmend #1 Per 1 Decedent's Name (First Middle Las	Phy G855 5/09/	os Gertific	ate of Death		Reg. No.		17767
	Physici	an	1. Decedent's Name (First, Middle, Las.	M CALLE		ino	2. Date of De Month	Day	Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give			ity, Town, or Location of De	MAY	4c. County	006	7.JUIT M
	Examir	er		LOSPITAL CE	V9 ER RA	NPALLSTOWN	aut	BALT	1000	28.
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. ia	st birthday) II Un	der 1 Year If Under 24 H		rth	9. Birthpla	ace (State or Foreign
	Director		3/0-03-4/19	X ^M ² □ F 88	Yrs.	ns Days Hours Mi	8. Date of Bi (Month, D 09/30/19	917	PA	y)
	pus *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				100	d. Inside City Limits
	Maryla f eho	ō	CT Fairfield	1	walk					1 □ Yes 2 □ No
	288-	rect	10e. Street and Number		10f.	Zip Code		10g. Citizen of V	Vhat Countr	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or iteme 23a or 28a-f show imatic event. The Mudical Examinar must be notified as imatic event.	Funeral Director	38 Donahue Drive		0	6851		U.S.A.		
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		cedent of Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)		e - Americai k, White, et	
ð	or it	by Fu	1 Never Married 2 Married	1 □XYes 2 □ No If Yes, Give WWII Year or Dates: WWII		s 2⊠ No Specify:	, ,		White	
Š	hours tural'	d b	3 ₩ Widowed 4 □ Divorced 15. Decedent's Edi		16a. Decedent's U	Inval Convention		16b. Kind of Bu		
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	be filed w ta! Hygier d other ti	Bec	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle	, Maiden Sumam	, , ,	
yland	Menta Menta arked	To	John Dino			Cather	ine Straka	S		
Mar	s 1 and 2 should if Health and Men item 27 is marke other traumatic	1	19a. Informant's Name/Relationship (T) Philip Dino/ Son	/pe, Print)	19b. Mailing Addr	ess (Street and Number or			State, Zip C	lode)
	1 and Health		20a. Method of Disposition	20b. Pla	ace of Disposition (rstown, MD	21136 20c. Location -	City or Tow	n State
Baltimore,	permit. Pages Department of I Important: If its eny injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐	CO	metery, crematory	or other place)			•	, o.u.o
	artme		4 Donation 5 Other (Specify. 21. Signature of Funeral Service License		22. Name	and Address of Facility	5305 Harri	Norwalk, (
n	permit. Depart Import eny inj		* VM	WIN & C	Leonar	d J. Ruck, Inc.	Baltimore	, MD 21214		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	. Do not enter the r	node of dying, such as card	ac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PNEUMON	PIL					Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequ						
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8/60,	cate be executed physician and the burial-tran it	dicail		d.						
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X Q Q	death certifi e ettending ed for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal	death 3 □Ectopi	pregnancy		23d. Dat	e ol delivery	y Day Year
j.	0 0 0	/sici	1 Yes 2 No	4 Pregnant at time of de 9 Unknown	ath 5 ☐ Other	(specify)				ay rour
7	law requires that the as been signed by th 2 should be detache	Completed by Physician/M	Part II. Other significant conditions co	ntributing to death but not resul	Iting in the underlyin	g cause given in Part I.	23e. Did	tobacco use conti	ibute to the	cause of death?
ďs,	w requires that been signed to should be det	d b	METABOLIC	ACIDOSIS.			10	Yes 2 □ No	3 Probab	bly 4 Unknown
ecora	w req	lete	ATHEROSCLEROTIC	CARDIOVA	SCULAR	DISEASE	24a. Was	an 24b. V	Vere autops	sy findings available pletion of cause of
r	The la	mo	PI PICTOSCACIO		, , , , ,	, , , , , ,	auto	ormed.	rior to compleath?	_
VII		Be C	25. Was case referred to medical			26. Place of D	1 Yes eath (Check only		□ 1 03 2	
> 0	Physicien: this certific ral director,	To E	examiner? 1 □ Yes 2 No	Hospital: 1 → npatient 2 □ E	R/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Res	idence 6 □Oth	er (Specify)	
<u> </u>	ည်း ရွှဲခွဲ		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurr	ed	
210	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Blood of Injury - At hor	M	1 Yes 2 No	281 Location	(Street and Numb	er or Rum I	Paula Number
DIVISION		Certification;	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)))	tory, office		iwn, State)	o, or ⊓ural l	TODIO (40/1108/)
_	To the Hospitel of within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 Certifying Phy	sician: To the best of my know	rledge, death occur	red at the time, date and pla	ce, and due to the	cause(s) and ma	nner as stat	ted.
	n 24 } n 24 } he Fu	Medical	(Check only 2 [*] Medical Exam one)	ner: On the basis of examinati and manner stated.	on and/or investigat	ion, in my opinion, death oc	curred at the time	, date and place, a	and due to the	he cause(s)
	To the within 2 To the I complet	Ž	29b. Signature and tille of certified	PAYSICIAN	1	29c. License number		29d. Date signed	(Month, Da	ay, Year)
1			After M	,		7 48103				

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A RALL MARK 15 H

31. Date liled (Month, Day, Year)

MAY 0 9 2006

NORTHWEST HOSPITAL CENTER.

5401 OLD COURT BOAD

mp 21133

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Item 19a per 1h 8855 5-9-06 vt
State of Manyland / Department of Health and Mental Hygiene of Communications.

		ĺ	1 - For State Registrar	State of	Marylan		aftment rtificate			ind M		g. No.	16	14425
я	Physici	an	Decedent's Name (First, Middle, Las								Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	Vivian Hill Dorse				I			15	May	3 20		5:11 AM
	Examin	er	4a. Facility Name (If not institution, give	street and nun	nber)		4b. City,		Location o			4c. County	rfore	- J
	Company		217 Valley Rd. 5. Social Security Number 6. Se	ix	7. Age (In yrs.	last birthday)	If Under		rdeer	-	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
	Funeral Director			☐ M 2 💢 F	60	Yrs.	Months	Days	Hours	Min.	(Month, Day, July 27	Year) 1945	NC NC	itry)
	P .		Usual Residence of Decedent											
	arylar show	ايا	10a. State 10b. County Harfor	ط	10c. Cit	y, Town or Lo Aberd							1	0d. Inside City Limits 1 ☐ Yes 2 No
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	with t		10e. Street and Number				10f. Zip				"	Og. Citizen of V		my:
	ns 23	Funerai	217 Valley Rd.	12. Was Dece	dent Ever in U	.S. 13.		1001 ent of His	spanic Orig	gin? (Spe	cify Yes or No-	USA 14. Rac		an Indian,
36	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show dissi Eval., or must be notified at	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 ※ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 X No 'e		If Yes, spec 1 ☐ Yes 2	ify Cubar	Specify:	, Puèrto I	Rican, etc.)	Specify	k, White,	_{etc.} ack
21215-0036	72 hours "natural", dicul Ex	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usua kind of wor	I Occupa	tion	af wantel		16b. Kind of Bu	usiness/în	dustry
215	⊆ ⊇	Completed	(Specify only highest gra-	College (1	-4or 5+)	life.	DO NOT us	e retired)	uning most	OI WOIKII	,g			
7	filed with Hygiene other than	Con	11	n/a_		Cus	todiar	-						erage Co.
Maryland		To Be	17. Father's Name (First, Middle, Last) James Hill								(First, Middle, M		,	
lan	and and sm	•	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or Town,	State, Zip	Code)
	- N -		Vera H. Rosea/g	randmo		-			Ct.					MD 21030
Baltimore,	S to to		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □	Removal from	State	Place of Dispo cemetery, crea	matory or ol	her place		5/8/6	06	20c. Location -	•	
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Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Michael J. Fig.	igie	$\overline{}$	L	emmoi	n Fu Pac	nera donia	Ho!	me of D	ulaney nium, M	Vall MD 2	ey Inc. 1093
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only			h. Do not ent	ter the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		8						
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	intifica ing ph a as th	Med	IF FEMALE:											
Вох	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		inth 2 ☐ Feta	Ideath 3	⊒Ectopic pr					23d. Dat Mo	te of delive nth	ery Day Year
0.	tt the dea by the a tached f	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	ant at time <i>o</i> f d own	eath 5	Other (sp	ecify)						,
Δ.	that the detac		Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the u	inderlying ca	ause give	n in Part I.		23e. Did tob	acco use cont	ribute to ti	ne cause of death?
ds,	uires sign	d by									1 X Ye	s 2 🗆 No	3 ☐ Prob	ably 4 Unknown
ecords,	w requ	Completed	-								24a. Was a	n 24b. V	Vere auto	psy findings available
α	9 4 9	dwo									autops perform	hed?	death?	mpletion of cause of 2□ No
Vital		0	25. Was case referred to medical		*				26. Place	of Death	1 ☐ Yes 2		10100	2 110
\leq	d is	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 🗆 I	npatient 2	ER/Outpaties	nt 3 🗆 DO	A Othe	r.		ne 5. ☐ Reside		er (Specif	(Y)
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of	of Injury th, Day Year)	28b. Time o	f 2	8c. Injury Work	at ?	2	28d. Describe ho	w injury occur	red	
Sio	ttandii death. ctor: A y the fu	catic	2 Accident investigation				М		'es 2 □ l	-				
Division	n b	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place	of Injury - At he ng, etc. (Specif	ome, farm, st	reet, factory	, office		2	28f. Location (St City or Town		er or Rura	il Route Number,
	To the Hospital within 24 hours at To the Funaral Completely filled it	edical Ce	29a. Certifier 1 Certifying Ph (Check only one)	iner: On the ba	asis of examina									
	o the ithin 2 o the ormple	Med	29b. Signature and title of certifien	and manr	ioi siated.		290	. License	number		2	9d. Date signe	d (Month,	Day, Year)
	F3F8		1 hunde	Se.	- 1	ar	1	127	309	G		5/5/1	56	
	1		30. Name and address of person who	completed caus	e of death (Item	n 23a) (Type.	Print)	, ,	J - 1	1		1211		
	2		Promila Suri/M.D		55 W.			lkto	n. M	D 21	921			
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ature	A	_	- 1 × 1	لطبصد	A.C			
	Registi	rar	MAYAA	2000	20	20	Anna de	2						

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore,

	Please Type or Print in Black Indelible Ink. Ensure Al	ll Copies Are Legible.
For	State of Maryland / Department of Health and M	lental Hygiene
For State Registrar	Certificate of Death	Reg. No.2 0 0 6
1. Decedent's Name (F	irst, Middle, Last)	2. Date of Death
RICHARD	DUTTENHOEFFER	MAY 2 2006

4b. City. Town, or Location of Death

TIMONIUM

7. Age (In yrs. last birthday)

Yrs.

78

02:50a M

4c. County of Death

BALTIMORE

29d. Date signed (Month, Day, Year) 5/2/06

200	Physici /Medic Examin	a
	Funeral Director	
	land ow	

Direct

Funeral

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Completed

Be

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by Physician/Medical

Completed

Be

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Certification:

Medical

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

MAY 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Pegistrar's Signature

1 M 2 ☐ F

4a. Facility Name (If not institution, give street and number)

STELLA MARIS

5. Social Security Number

073-22-0164

rthan "naturel", or iteme 23a or 28a-f eh the Medical Examiner must be notified i and Mental Hygiene. permit. Pages 1 and 2 a Department of Health ar Importent: If Item 27 le any Injury or other trau

Physician /Medical Examiner

The law requires that the death certificate be executed Records, P.O. Box 68760, the á cate has been signated by page 2 should b certificate of Vital or Attending Physician: this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral Division Hospitel

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8. Date of Birth | 9. Birthplace (State or Foreign | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | NEW YORK | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MDBALTIMORE SPARKS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 FAR CORNERS LOOP 21152 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CIVIL ENGINEER ENGINEERING 4YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ADAM DUTTENHOEFFER NETTIE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN DUTTENHOEFFER(WIFE) 30 FAR CORNERS LOOP SPARKS, MD. 21152. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ARLINGTON NATL. 06/15/2006 ARLINGTON, VA. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 2 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEUKEMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the design of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 🛣 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The discal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

DHMH 17 Rev 1/2001

29c. License number

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

372

			1 - For State Registrar	State of Maryland		artment o			ital Hygie	12 C C C	27		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Estelle A. Dems	ski					Date of Death Month ay 7,	Day Year	3. Time of Death 7:20 A.M		
	Examin		4a. Facility Name (If not institution, give s 409 Linda Avent	·		4b. City, Tow Linthi	n, or Location		q	4c. County of Deat Anne Ar			
	Funeral Director		Social Security Number 6. Sex			If Under 1 Ye		24 Hrs. R	Date of Birth Month, Day, Ye	9. Birt	hplace (State or Foreign buntry) ryland		
	ryland how Let		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits		
	the Ma	ecto	Md n/a		В	altimo			100	Citizen of What Co	1 Yes 2 No		
	th with 23a or	al Di	3015 Mardel Ave	enue			21230			USA			
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, then "naturat", or Items 23a or 28e-f show item 27 is marked other than "naturat", or Items 23a or 28e-f show other treumatic event, the Medical Everities frings for rediffied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent f Yes, specify (1 ☐ Yes 2 🔀			Yes or No- in, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	nin 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation o completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re	one durina mos	st of working	168	o. Kind of Business/			
212	e filed within al Hygiene. I other then " vent, the Mu	Com	12	0	F	actory				anufact	uring		
Maryland	should be fi and Mental H s marked otl umatic ever	To Be	17. Father's Name (First, Middle, Last) Frederick Wisn	den Sumame) WSki									
lary	2 shou and M is mar	_	19a. Informant's Name/Relationship (Type	pe, Print)			eet and Numb	er or Rural Ro	oute Number, C	ty or Town, State, 2			
Baltimore, N	ges 1 and it of Health It item 27 or other tr		Mrs. Veronica 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	ace of Dispo metery, cren	sition (Name o natory or other	f place)	Date	200	eights,	Town, State		
altim	permit. Pages Department of H Importent: If ite eny injury or of		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		The second secon	islau:		5/10/	06 Ba	ltimore	, Md.		
ă	Depa Impo eny ir		Frehat Jahrola	in)	12	201 Dui	ndalk	Ave.	Baltin	ore, Md	. 21222		
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that aused the death. te cause on each line. Due to (or as a conseque	التمت	er the mode of	dying, such as	s cardiac or res	spiratory arrest,		Approximate Interval Between Opeet and Death		
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oʻ	ate be executed only sician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease of Injury) that initiated events resulting in death) Last	Due to (or as a conseque	ence of):								
8760,	icate be physicia s the bu	dlcal											
.O. Box 6	death certif e attending od for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3□	Ectopic pregna Other (specify				23d. Date of delivery Month Day Year			
ecords, P.	requires that the de leen signed by the a hould be detached t	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the u	nderlying cause	given in Part	l.	23e. Did tobac		the cause of death?		
$\mathbf{\alpha}$	The law ate has b page 2 sl	Completed							24a. Was an autopsy performed	prior to death?	itopsy findings available completion of cause of		
Vital	Physicien: Th this certiticate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ➢ No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	it 3 DOA	Othor	e of Death <i>(Cl</i> ursing Home		e 6 X Other (Spec	DAUGHTER'S		
ion of	Jing J. After fune	ation: T	27. Manner of Death Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. 1	njury at Work? 1 □ Yes 2 □	28d.	Describe how i		iny) IZE-3 (GE SCE		
Division	P Pir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, off	ice		Location (Stree City or Town, S	eet and Number or Rural Route Number, , State)			
	e Hospital 124 hours a e Funeral letely tilled	edical		sician: To the best of my know ner: On the basis of examination and manner stated.									
	To the within 2 To the complex	Me	29b. Signature and title of certifier	1/2	>	29c. Lic	ense number	L 7-)	29d.	Date signed (Monti	h, Day, Year)		
,	27		30. Name and address of pers	mr leled cause of death (Item)	23a) (Type	Print)	15)	15/	10 To 10 To 10	ay 8,	2006		
	8		(Lussella	Delher 30	54	Eideo	el Os	me)	5/ens	Monne	2104		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 9 200	32. Registrar's Signatu)TO	W.		-			1		

			For State Registrar	State of Ma	aryland	l / Depa	artment of F	lealth a Death	and Mei		ene2	106	14428	
			1. Decedent's Name (First, Middle, La	st)					2.	Date of Death	1		3. Time of Death	
	Physicia /Medic		Lola Yolanda	DiStefar	10				м	Month ay 7,	Day - 2006	Year	11:00Å	
	Examin		4a. Facility Name (If not institution, given				4b. City, Town, o	r Location o	of Death	ay / 5	4c. Count			
Н			7422 Holabird	Avenue			Dunda	1 k			Ra1	timo	~ ~	
	Funeral		5. Social Security Number 6. S	Sex 7. Ag		st birthday)	If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day,		9. Birth	place (State or Foreign intry)	
М	Director		216-07-1364	1□M 2\\XF	85	Yrs.	Monard Bayo	110010		-27 - 1			MD	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits	
	Aaryli f sho	ō	MD Baltin	nore		unda							1 ☐Yes 2 🔯 No	
	28a-	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	intry?	
	with Ba or			A 33 0 m 44 0			2122	2					,	
	ns 2%	era	7422 Holabird 11. Marital Status	12. Was Decedent	Ever in U.S	. 13. \	Vas Decedent of H f Yes, specify Cuba		gin? (Specify	y Yes or No-	USA 14. Ra	ce - Ameri	can Indian,	
20	or Itan	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 27	10				i, Puerto Ric	an, etc.)		ick, White		
ğ	ral', c	by	3 Widowed 4 □ Divorced	If Yes, Give" Year or Dates:			I□Yes 2□XNo	Specify:			Specia	fy: Wh	ite	
2	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show Ita Madical Examiner maal be notified at	Completed	15. Decedent's E (Specify only highest gr			(Give	lent's Usual Occup kind of work done	during most	of working	1	6b. Kind of E	Business/Ir	ndustry	
21	han "	npl	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	OO NOT use retired	i) -						
N	filed v Hygie other t		17. Father's Name (First, Middle, Last	1			Homema		rta Nama /F	irst, Middle, N		_Hom	e	
anc	be fill Hall Hall Had of	Be										ne)		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heelth and Mental Hygiene. If Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic evant, Ir. M. Alcal Examiner must be notified at	To	Domenico Croche 19a. Informant's Name/Relationship			19h Mailin	g Address (Street			e Ful		State 7i	n Codel	
<u>a</u>	d2s than trau		Dee Schoeder -	* * *										
တ်	1 an Heel tem 2		20a. Method of Disposition	- Clanada	20b. Pla	ce of Dispo	sition (Name of		Date		Oc. Location			
<u></u>	Pages nent of int: If its iry or o		1 ☐Burial 2 ☐Cremation 3 ☐ 4 ☐Donation 5 ☐ Other (Speci		0 a k	metery, cren Law 1	natory or other plac n Cemte:	ry 5	5-10-	06	Balti	more	, MD	
altimore,	artme		21. Signature of Funeral Service Lice			22	. Name and Addre	ss of Facility	V B r a d				eral Home	
 Ba	permit. Pages 1 and 2 Department of Heelth a Important: If item 27 ii any injury or othar tra ance.		Elhallet	\rightarrow			A, 2134							
П		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Dementage Dementage The condition and the cause of the												
4	Pnysician		disease or condition	Dem	ent	ia							Onset and Death	
i.	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							J	
	LXuiiiiiioi	÷	Sequentially list conditions,	_										
	led nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	silce oi).								
•	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):								
8760	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E	l	d										
99	ficate p physics the													
Box	nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			IC				23d. Da	ate of delivery		
	that the death certificed by the attending posteroned for use as	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☑No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (s <i>pecify)</i>	<u> </u>			M	onth	Day Year	
P.O	t the by th tache	hys	9 ☐ Unknown	9□ Unknown										
'n.	res tha igned be det	by F	Part II. Dther significant conditions	contributing to death b	ut not result	ting in the ur	nderlying cause giv	en in Part I.		23e. Did tob	acco use con		the cause of death?	
ğ	w requir been si should	ted								1 🗆 Ye:	s 2 No	3 🗀 Pro	bably 4-Onknown	
Records,	has be	Completed								24a. Was an autopsy	,	Were auto	opsy findings available ompletion of cause of	
	ysician: The is certificate hadirector, page	Con								perform 1 Yes 2	ed?	death?	2E No	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				17-11		of Death (C	heck only one)			
	Physician: rthis certifica ral director, I	ို	1 Yes 2 No	Hospital: 1 ☐ Inpatie	-	R/Outpatien		4 🗆 1901		5 Hesider			fy)	
5	ding F	lon:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	Y Year)	28b. Time of Injury	Wor	k?		I. Describe ho	w injury occui	rred		
200	Mtendi death ctor: A y the fi	icat	2 Accident investigation 3 Suicide 6 Could not be	90 Place of Init	une At hom	a form str		Yes 2 □ N		Location (Str	eet and Num	har or Dur	al Route Number,	
Division of	or A after a Dirac in by	Certification;	4 Homicide determined	building, et			et, factory, office		201.	City or Town,		Der Or Mar	ai noute Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pl	hysician: To the best	of my know	ledge, death	occurred at the tin	ne, date and	d place, and	due to the ca	use(s) and m	anner as	stated.	
	24 h	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination	on and/or inv	estigation, in my o	pinion, deat	th occurred	at the time, da	te and place,	and due t	o the cause(s)	
	To th within Fo thi	Me	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signe	ed (Month,	Day, Year)	
	1		Caller Colore	£			1 51	185		i i	Maci	8.2	2006	
1	5		30. Name and address of person who Colleen Chusmas,	completed cause of d	eath (Item 2	23a) (Type,	Solutions Solutions	11- 1	3011	1	100	- 1 -	71770	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	Ire Park	BB	ue, E)a (hm	ure IV	aryla	He	61264	
	Registr	ar	MAY 0 9 200	A PARTER OF	D.	Carried Co			_	_				

			1 - For State Registrar	State o	of Maryla	nd / Dep <i>Ce</i>	artment					giene Reg. No.	200	6 14429		
	Physici /Medio		Decedent's Name (First, Middle Rodney	e, Last)	Lee	.		Eva	ns S		2. Date of Dea	Day	Year	3. Time of Death 6 6 50 P M		
	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)	LIMUR			Location LT//		ECIT	4c. Coi	unty of Dea	ath		
CVANS	Funeral Director		5. Social Security Number 219-78-9619	6. Sex 1 → M 2 → F	7. Age (In yrs	s. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Dat L 2 05	y, Year) 57	9. Bir	nthplace (State or Foreign ountry) MD		
	Aaryland Fahow	or	Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or L								10d. Inside City Limits 1√□ Yes 2 □ No		
156	death with the Maryland ms 23a or 28a-f show finant be notified at	Director	MD NA 10e. Street and Number			Balti	10f. Zip					10g. Citizen		ountry?		
DONGA	5 ≗ 5	by Funerai	3442 Dolfiel 11. Marital Status 1 Never Married 2 Marrial 3 Widowed 4 Noticed	12. Was Deci	12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Two				21215 Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify:					A. erican Indian, te, etc. Black		
3	Baltimore, Maryland 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours at bepartment of Health and Mental Hygiene. Mportent: If Item 27 is marked other than "naturel", or any injury or other traumatic event, the Madical Examples.	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	st grade completed)	on mpleted) 16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)						g	16b. Kind o	of Business			
F	laryland 212* 2 should be filed within and Menta Hygiene. Is marked other then sumatic event, the Menta Hygiene.	Be Con	12th grade 17. Father's Name (First, Middle,	Last)	a	I	nspec			er's Name	(First, Middle,			Maryland		
KNOWN	should by Ment marked	2	Garland Evans Sr. Helen Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
2	and 2 sealth ar m 27 is		Helen Evans-			3442	Dolf	iel		re, E	Baltim	ore,	Md	21215		
J K	imore, N Pages 1 and nent of Health out: If Itsm 27 iry or other tr		20a. Method of Disposition X□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	Place of Dispo cemetery, cre oulane	matory or ot	her place	1	5/9/0)6			Town, State Valley, MD		
PATIENT	Baltimo permit. Pag Department Importent: t eny injury o		21. Signature of Funeral Service	Licensee	, Ke	2 M	2. Name and arch	Addres F/H	s of Facili	ty S t				21215		
PA	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or hear the flure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a													
	Examiner	er		b. AR		INAL	- M	36C	ESS	5				2 WEEKS		
	5 E E & O	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):											
	r 687 attificate t ing physical	Medic	IF FEMALE:	d												
	VISION Of VITAI RECORDS, P.O. BOX 61 Attending Physician: The law requires that the death certific death. sector: After this certificate hes been signed by the attending p by the funeral director, page 2 should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live b 4☐Pregn	3c. If yes, outcome of pregnancy 1									23d. Date of delivery Month Day Year		
	Division of Vital Records, P.O. for Attending Physician: The law requires that the dather death. Director: After this certificate hes been signed by the lin by the funeral director, page 2 should be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc									bacco use d		o the cause of death? robably 4 ⊟Unknown		
	II Recor	Completed									24a. Was autop perfor 1 ☐ Yes	sy	4b. Were as prior to death?	utopsy findings available completion of cause of		
	Vital sician: 1 certifical rector, p	Be	25. Was case referred medica examiner?	Hospital:	/	7		Othe			(Check only o					
	Off Off ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 27. Manny of Death 1	28a. Date (Mon	patient 2 of Injury th, Day Year)	28b. Time o Injury		Bc. Injury Work	4 🗀 NU	2	e 5 🗆 Resid			ecify)		
	Divisio	Certification:	2 Accident investig	not be 28e. Place	of Injury - At I	home, farm, st					Bf. Location (S City or Tow		umber or R	ural Route Number,		
	DIVI To the Hospital or Al within 24 hours after of To the Funsrel Direct completely filled in by	Medical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Physicien: To the Exeminer: On the band mani	best of my kn asis of examin ner stated.	nowledge, deat ration and/or in	h occurred a vestigation,	it the tim in my op	e, date an pinion, dea	id place, a	nd due to the o	cause(s) and date and place	d manner as ce, and due	s stated. e to the cause(s)		
	To the I within 2 To the complete	Me	29b. Signature and title of certifie		3.B-	S.	29c.	License	number	00	5	29d. Date sig	gned (Mont	th, Day, Year) 2006		
	5		30. Name and address of person	who completed caus	se of death (Ite	om 23a) (Type,	Print) -B-S	5	INA	HF	105P17	TAL	OF BI	AITMORE		
	Sta Registr		31. Date filed (Month, Day, Year)	2006 326A	legistrar's Sign	nature	and of									

			Tor State Registrar	State of M	arylar		artment of H		d Mental Hy	giene Reg. No	$Z \cup U \cap$	5 14430				
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of Di	Па	y. Yea	3. Time of Death				
4	/Medio		James Alexand						may 6) (3006	4:20 PM				
1	Examir	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or		Death	4c	. County of De					
			5. Social Security Number 6. Se	2 4	o /In vrs	last birthday)	Baltin If Under 1 Year	If Under 24	Hrs. 9 Date of Pi	#b	N/A					
	Funeral Director			7 M 2□F	2	Yrs.	Months Days		Min. 8. Date of Bi	ay, Year)	003 Md	Sirthplace (State or Foreign Country) WYLANd				
	ס		Usual Residence of Decedent						000. 2	ا ک و ک	UUJ MIL	vigiunu				
	urylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits				
	8a-1:	Director	Maryland Harford			Jopp	а					1 🗆 Yes 2 🔀 No				
	with th	E C	10e. Street and Number	d Doad			10f. Zip Code	01005		10g. Ci	tizen of What	•				
	s 23	erai	313 Spry Islan	12. Was Decedent	Ever in I	S 12 1	Mac Dagadent of Hi	21085	2 /Specific Vac or N		U.S.A	nerican Indian.				
10	d within 72 hours after death with the Maryland Jiene. I then "naturel", or items 23a or 28a-f show Itte Mudical Examilier must be natified at	Funerai	1 Never Married 2 Married	Armed Forces	1	.3.	f Yes, specify Cuba	n, Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	0-	Black, W					
93	el', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No	Specify:			Specify: ()	hite				
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Usual Occupa	ation	working	16b. K	ind of Busines	ss/Industry				
21	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired)	······································		4771					
72	filed within I Hygiene. other then		17. Father's Name (First, Middle, Last)			Net	ver Worke		Name (First, Middle	Maidar	N/A					
and	o a b	9 Be	Mark Friedly					Anna			Sumame)					
Maryland 21215-0036	s 1 end 2 should k f Health and Ment frem 27 is marked other traumatic	은	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street a		r Rural Route Numb		or Town. State	. Zip Code)				
	nd 2 alth ar		Anna Friedly (21085												
Baltimore,	of Health of Health fitem 27 r other tr		20a. Method of Disposition		20b. F	- Karana and a second	sition (Name of natory or other place		ad, Joppa,		ocation - City	or Town, State				
ш	Pag lent nt: I		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				Crematory		12/2006	Bali	imore.	Maryland				
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	500				s of Facility	Schimunek	Fune	eral Ho	imes				
_	99 E # 9		23a. Part1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx													
			shock, or heart failure. List only of	lications that chused one cause of each li	d the deat ne.	h. Do not ente	er the mode of dying	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between				
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MYOCG	erclit	75						Onset and Death				
	/Medical Examiner		resulting in dealth)	Due to (or as a consequence of):												
	3	e.	Sequentially list conditions, in the sequence of the sequence													
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
V.	an an rial-tr		resulting in death) Last	Due to (or as	a conseq	uence of):										
8760,	icate be executed physician and s the burial-transit	dlcat		d												
9	death certifice attending pt for use as t	Med	IF FEMALE:	Marine and												
Вох	death certifii e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Feta	Ideath 3□	Ectopic pregnancy				23d. Date of d Month	lelivery Day Year				
0		yslc	1 □ Yes 2 □ No 9 □ Unknown	4∏Pregnant a 9∏ Unknown	time of d	eath 5	Other (specify)					,				
Ω.	requires that the d reen signed by the hould be detached	F.	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did 1	obacco u	use contribute	to the cause of death?				
ds	n sign	d by	seizure disorc	ber, fa	dure	to	thrue		10	Yes 2	DNo 3□1	Probably 4 Unknown				
8	w requir s been si should	jete							24a. Was	an	24b. Were	autopsy findings available				
æ	The law ste hes b bage 2 sl	Completed							— auto perfo	psy ormod? 2 No	prior to					
ita		Be C	25. Was case referred to medical					26. Place of	Death Check only		1216	212410				
Division of Vital Records,	Physiclan: this certific	10 E	1 105 2 2 140	Hospital: 1 Inpatie	ent 2 🗆	ER/Outpatien		4 [] (4015)II	ng Home 5 ☐ Resi	dence	6 □Other (Sp	pecify)				
Ē	ing P		27. Manner eath 1 Ulatural 5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how inju	y occurred					
sio	Attending in death. setor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be					res 2 □ No		_						
<u>></u>	or At after c Direc in by	Certification;	4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specif	ome, tarm, stre y)	eet, factory, office		28t. Location (City or To	Street an wn, State	d Number or I	Rural Route Number,				
_	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy	sician: To the best	of my kno	wledge, death	occurred at the tim	e, date and of	ace, and due to the	cause(e)	and manner	as stated				
	P Ho	edicai	(Check only 2 Medical Exam	iner: On the basis o and manner st	t examina	tion and/or inv	estigation, in my op	pinion, death o	occurred at the time,	date and	place, and di	ue to the cause(s)				
	To the To the To the Complet	Me	29b. Signature and title of certifier				29c. License	number		29d. Dai	te signed (Mor	nth, Day, Year)				
			Im (Luch	elic me)		1738	127		Ma	4 6,0	7066				
	1		30. Name and address of pers if who c	omp and cause of o		23a) (Type,	Print)	211	invoire Mo	ade	m 511	7 (5				
	M		Haron Lickerbe	ns mo			respital	EXILT	unate tik	· YKI	ru al	40				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ars Signa	ture	certi									

Pt. Known as James Alexander Friedly

		1	1 - For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of H	ealth and Death	l Mental Hy	giene	006	3
	Dhysisi	212	1. Decedent's Name (First, Middle,	Last)					2. Date of Do	eath Day	Year	3. Time of Death
	Physici /Medic		James	tuller				_ -	Max	3	2006	3:45 M
-	Examin	er	4a. Facility Name (If not institution,	N	11		4b. City, Town, or	Location of De	ath	4c. Co	unty of Death	
			5. Social Security Number		Age (In yrs. i	he.	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi			place (State or Foreign
п	Funeral Director		231-40-6787	1 X XM 2□ F	7.		Months Days	Hours M		ay, Year)	Cou	ontry)
			Usual Residence of Decedent						AUG Z4	1934	VIP	GINIA
	rylan how		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	MARYLAND N/A			BALTIM	ORE					1 TyYes 2 No
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	s 23a	ral	1903 E JEFFERS	ON STREET	ant Suprin II	e 112.1		.205	(Casaity Van as N		Race - Ameri	oon Indian
	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Ford	es?	3.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)	14.	Black, White,	
8	urs a	by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dat	3055		1 ☐ Yes 2 XX No	Specify:		Sp	ecify: BLA	CK
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28a-f show that the Madical Examinat rivet be confilled at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occupa	ation	vorkina	16b. Kind	of Business/Ir	dustry
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4	for 5+)	life.	DO NOT use retired)	ioning			
	led w lygier her th		12th grade			SEC	URITY GUA		lama /Fina Middle		IS SECU	RITY
anc	l be fi	Be	17. Father's Name (First, Middle, La						am <i>e (First, Middle</i>		mame)	
Maryland	should nd Men marke umetic	BENJAMIN FULLER BENJAMIN FULLER ARDELL FULLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number,										Code)
<u>≅</u>	and 2 sealth ar n 27 is		Bertina Johnson				3 E Jeffe					
ē,	s 1 ar f Hea item other		20a. Method of Disposition	,		lace of Dispo	sition (Name of natory or other place	1	Date		ion - City or T	
E	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		ate		FOREST		10-06	OWING	S MILI	S, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28a-f show any injury or other treumetic event, the Medical Examinating the notified at Once.		21. Signature of Frieral Li	censee			Name and Addres		OMMINITON	ם שוווים	AT LION	TE D 7
<u> </u>	89 = 9		23a. Part1. Enter the disease, or c			1	206 W NOR	TH AVEN	UE		TIOP.	L F.A.
8760, 6	/Medical Examiner. but provided and provided and the prival-transit the prival-transit the prival-transit priva	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury that initiated events resulting in death) Last	b Due to (o	r as a consequ r as a consequ r as a consequ	uence of):	PHIL	ure				
.O. Box 68	death certiff e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 □ Live bir 4 □ Pregna 9 □ Unknov	death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year			
s, D	quires that n signed b uld be deta		Part II. Other significant condition HYPECTENSI		th but not resu	ulting in the u	nderlying cause give	en in Part I.		tobacco use o		he cause of death?
Vital Record	ysicien: The law requires that the is certificate has been signed by th director, page 2 should be detach	Completed by	ATTAMIA						24a. Was auto perfo		4b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						eath (Check only	one)	30 m. 20-4	
Division of \	utending Physicien: death. ctor: After this certific t the funeral director,	2	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month)		ER/Outpatier 28b. Time of Injury	28c, Injury Work	Nursing	Home 5 Res			(y)
Divis	tel or Atte s after de el Directo	Certification:	3 Suicide 6 Could no determin	ed 28e. Place o	f Injury - At ho g, etc. <i>(Specif</i> y		eet, factory, office		28f. Location (City or To		u <i>mber</i> or Rura	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	one)	Physician: To the bastaminer: On the bastand manner	est of my know is of examinat or stated.	wledge, death tion and/or in			ce, and due to the curred at the time,			
	To T Comm	Σ	29b. Signature and title of certifier	u La	lhan	n'	29c. License	number -8575		29d. Date si	gned (Month,	Day, Year)
	4		30. Name and address of person w	AKHAN	11. 72	20 /	Print) ARK H	ELCAIT	AVE	BAL	TO M	12120f
. E	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 20	06 2. Re	gistrar's Signa	ture	NE .	, , ,	,			

			1 - For State Registrar	State of	Maryland		rtment tificate				1entai Hy	/gien Reg. N	Z U	06		32
			1. Decedent's Name (First, Middle, Last))							2. Date of D	eath			3. Time of	Death
н	Physici			Maliha	Fakhou	ıri					Month May	6,	¹ ay 2	006	8:28	B P ^M
j		/Medical Examiner 4a. Facility Name (If not institution, give street and number)						Town, or	Location	of Death				ty of Death		
1			Suburban Hospita	1			Bet	hesc	la				Mor	ntgome	erv	
	Funeral		5. Social Security Number 6. Sec	x :	7. Age (In yrs. la.	st birthday)	If Under		If Under		8. Date of Bi	irth Van			place (State ontry)	or Foreig
	Director		106-64-5458]M 2∏XF	85	Yrs.	Months	Days	Hours	Min.	July 4			Leba		
	<u> </u>		Usual Residence of Decedent													
	rylar	_	10a. State 10b. County		10c. City,	Town or Loc	cation							1	10d. Inside C	-
	e Ma	cto	Maryland Montgome	ry	K	ensing	gton								1 🗆 Yes	2 <u>X</u> No
	th th	lre	10e. Street and Number				10f. Zip	Code				10g. C	itizen o	f What Cour	ntry?	
	23a	a	3618 Littledale R	20	895				Uni	ted	State	s				
	within 72 hours after death with the Maryland ene. than 'natural', or Iteme 23e or 28e-f ehow ta Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Armed Forces?				Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto				0-	14. Ra	ace - Americack, White,	can Indian,	
9	or It		1 Never Married 2 Married		1 ☐ Yes 2 🔀 No				Specify:		, , , , , ,					
Ö	ural',	d by	3XXVidowed 4 □ Divorced If Yes, Give Year or Dates:										эрөс	^{i/y:} Whit		
ν.	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>		16a. Deced (Give	ent's Usua kind of wor OO NOT us	Cocupa k done c	ation during mos	t of work	ing	16b.	Kind of	Business/In	dustry	
2	hen a	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+))							
'n	led v tygie her t		17. Father's Name (First, Middle, Last)	4		Exe	cutiv	e	40.14-45	1 11-	(F) 1 14: ((I	-		tisin	g	
Maryland 21215-0036	be fi	Be									e (First, Middle			ime)		
7	ould Mer Park	으	Ahmad Lababidi								ya Fakh					
ā	12 st and ris n		19a. Informant's Name/Relationship (Ty	-			_				al Route Numb				•	
	l and fealth im 27		Sameh A. Fakhouri	/ Son	20h Die	2/ Ho.	LTA D	rive	, Net		chelle,					
altimore,	ges to the life or of		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	Removal from S		ce of Dispos netery, crem				May		200.	Location	- City or To	own, State	
Ē	men tant: lury		4 □Donation 5 □ Other (Specify)		Montg	gomery (200					arylan	
Ba	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show apportant plury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service License	nut	M0130	5 Rol	Name and Dert A. 57 Wis	Addres Pum consi	phrey phrey n Aver	Funei Tue, B	ral Home, ethesda,	/Beth Mar	nesda vland	-Chevy 1 20814	Chase,	Inc.
			23a. Part1. Emer the disease, or compli shock, or heart failure. List only or	ications that ca	used the death.										Approximat Interval Bet	ie ween
	Physician		Immediate Cause (Final disease or condition		sepsis										Onset and I	
1	/Medical		resulting in death)	4	or as a conseque	nce of):										
	Examiner				urrent		atio	n								
		Jer	Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (c	я ав а вопендив	nec of).										
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	Diure	esis Treat	ment fo	or Cong	esti	ve Hea	rt Fa	ilure an	d Fe	ver			
o	exection and and rial-tr	Ex	resulting in death) Last		or as a conseque											
8760,	icate be executed physicien and the burial-transit	dlcall		d												
89	tifica ig ph as th	led														
Division of Vital Records, P.O. Box	The law requires thet the death certificate has been signed by the ettending tage? should be detached for use as	Physician/Me	E IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy									ate of delive	өгу			
<u>m</u>	deat e ett	Cla	in the past 12 months? 1 □ Yes 2 🏿 No	4☐Pregna	int at time of dea		Other (spe						N	lonth	Day ^	Year
Ö	t the by th	hys	9 🗆 Unknown	9 Unkno	wn											
ري م	s the	by P	Part II. Other significant conditions cor	ntributing to dea	ath but not result	ing in the un	derlying ca	use give	n in Part I		23e. Did	tobacco	use co	ntribute to th	he cause of d	Jeath?
ĕ	ne law requires ti s has been signe ge 2 should be c	pa	Atrial Fibrillation	on, Hyp	erthyro:	idism,	_Oste	оро	rosis	3	1 🗆	Yes	2 🕅 No	3 ☐ Prob	ably 4 □t	Jnknown
ပ္ပ	s bee	Completed									24a. Was	s an	24b	. Were auto	psy findings	available
æ	he la e ha:	EC.										ormed?		death?	psy findings mpletion of c	ause of
ā	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical						00 Diag	(D 1)	1 ☐ Yes	2 X N	lo	1 🗆 Yes	2∐ No	-014
>	s cert irect	00	examiner?	lospital:	patient 2 🗆 El	R/Outpatient	3 □ DO	Othe	200		Check only		a □ 0	· · · · · · · · · · · · · · · · · · ·	()	
ō	Attending Physician: or death. ector: After this certifici by the funeral director, I	7. To	27. Manner of Death	28a. Date of	f Injury 2	8b. Time of		c. Injury Work			me 5 Res 28d. Describe				y)	
0	th. : After tuner	盲	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	n, Day Year)	Injury	м		(? ∕es 2 🔲	No			•			
18	Atter dea ctor	Certification:	3 Suicide 6 Could not be	28e. Place	of Injury - At hom	e, farm, stre	et, factory.	office			28f. Location	(Street a	and Nun	ber or Rura	I Route Num	iber.
ă	after Dire	ert	4 Homicide	buildin	g, etc. (Specify)						City or To	wn, Sta	te)			,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely tilled in by the tuneral director, page		29a. Certifier 1 X Certifying Phys	sician: To the t	best of my knowl	edge, death	occurred a	t the tim	e, date an	nd place,	and due to the	cause	s) and n	nanner as s	tated.	
	P Ho 124 h	Medical	(Check only 2 Medical Examinations)	ner: On the bar and manne	sis of examinatio	n and/or inv	estigation,	in my op	oinion, dea	ith occurr	ed at the time,	date a	nd place	, and due to	o the cause(s	;)
	To the within To the comple	Me	29b. Signature and title of certifier	> .			29c.	License	number			29d. D	ate sign	ed (Month,	Dey, Year)	
)	/		Kamalinel	Des	up and	0		ከበበር	20415			Мa	v 6	, 2006	5	
/	1		30. Name and address of person who co	mpleted cause	of death (Item 2	(Type F						1,19	. y 0	, 2000	,	
5			Kamalinee Deshpan		•			lock	ville	, Ma	ryland	208	352			
Ĭ	Sta	te	31. Date filed (Month, Day, Year)	32.	gistrar's Signatu		ants				<u>, </u>					
	Registr		MAY 0 9 20	006	Deser S	The Sales	STATE OF THE STATE									

3 la 00

FAKHOURT, NALTHA

Please Type or Print in Black Indelible Ink

Deanna Camille Gr	1- For State Certificate of Death		eg No. 2006	11.1.2
Physician/	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month		Time of Death
Medical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lor	May 5, 20	4c. County of Death	2116 hrs
1.	Sinai Hospital Baltimore			
Funeral Director	Months Days	If Under 24Hrs. B Date of Bir Hours Min.	th (MM/DD/YYYY) 9. Birthp Foreign Count	lace (State or
	220-35-3697 1 M 2 XF 1 4 Yrs. Usual Residence of Decedent	5-21	-177a count	'y) 111 V
w any	10a. State 10b. County 10c. City Town or Location		11	Od Inside City Limits Yes 2
the Maryland a or 28a-f show tified at once.	10e. Street and Number 10f. Zip Code	<u> </u>	0g. Citizen of What Country	
with the Maryland as 23a or 28a-f sho be notified at once.	19611 Wesland Circle 211	33	USA	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once ted by Funeral Director	1 X Never Married 2 X Married Armed Forces? If Yes, specify Cuban, M	nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.)	- 14. Race - America White, etc.	n Indian, Black,
s after de ral", or niner mu by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	pecify:	Specify: Blo	ick
hours a	15. Decedent's Education (Specify only highest grade completed) Elementary/Secologry (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation during most of working life. Dr.	(Give kind of work done O NOT use retired)	16b. Kind of Business/Ind	ustry
5-0036 led within 72 hour. Hygiene. other than "natu the Medical Exan Completed	Studer	it.	NIA	,
	17. father's Name (First, Middle, Last)	Mother's Name (First, Middle, M	aiden Surname)	\
2 Mer s	1 a. Informant's Name/Relationship (Type, Pright) 19b. Mailing Address (Street an	nd Number or Rail Route Num	nber, City or Town, State, Z	p Code)
MD and 2 sh salth an em 27 i	Anthony W. Green / Father 9611 Wesland 20a. Method of disposition (Name of cemet	Cr. Kanda ery, Date	lustown, m	0 21133
Baltimore, permit Pages I a Department of He Important: If it	1 Burial 2 Cremation 3 Removal from State crematory on other place)	101.01.1	Tivas ila	mb
Baltimo permit Pag Department Important: injury or of	4 Donation 5 Other Specify 21 Signature 6 Funeral Service lice see 28 Name and Address 6	5/13/06 Facil Greene Fi	Mra L Seri	irces
	23a. Part Unter the disease, or complications that caused the death. Do not enter the mode of dying, sur	hy Ed., Randa	Ustown, And	
Physician	failure List only one cause on each line. Immediate Cause (Final disease a electrocution		in the state of th	Between Onset and Death
xaminer	or condition resulting in death) Due to (or as a consequence of):			
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ted Insit	(Clease or in jury that in Mated events resulting in death) Last Due to (or as a consequence of):			
	UNPENDED THE G855 5/3	22/06 TH		
60, Kate be exect of the burial - tr	IF FEMALE: 23c. If yes, outcome of pregnancy	22/00 JH	23d. Date of delivery	
Box 6876 death certificat the attending ph dfor use as the rysician/M	123h Mas decedent pregnant in the	Ectopic pregnancy	Month Day	Year
b. Box 687(the death certification by the attending piched for use as the Physician/A	1 Yes 2 No 9 V Unknown 9 Unknown		<u> </u>	
P.O. E s that the d gned by the e detached by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give		bacco use contribute to the	
Records, F The law requires ficate has been sign page 2 should be of Completed t		24a. Was a		sy findings available
Reco The law cate has page 2 s		autop perfor	med? death?	pletion of cause of
Vital Revysician: The his certificate director, page	25. Was case referred to medical 26. Place of examiner?	Death (Check only one)		
ding Physi After this funeral dir	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury a		Residence 6 Other:	
ion of trending leath tor: At the fur ation	1 Natural 5 Pending May 5, 2006 2016 hrs 1 Yes	Subject con	tacted electrified fend	ce
Division of Vital Records, P.O ospital or Attending Physician: The law requires that thours after death neral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be dead Certification: To Be Completed by F	3 Suicide 6 Could not be determined (Specific) Park (Page Street, Factory, office build	or Town, S		
Dir e Hospital of 1.24 hours a e Funeral Letely filled	4 Homicide Park/Recreation Area 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date.)		Orive, Baltimore, M e(s) and manner as started	
To the 110 within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated			` <u></u>
^	29b. Signature and title of certifier 29c. License n O.C.M.		29d. Date signed (Month May 6, 2006	∪ay, Year)
1)	30. Name and address of person who completed cause p death (Item 23a)			
γ\	Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltin 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nore, MD 21201		
State Registra	12 A - A - A			

DHMH 17 Rev 1/2001 OCME 2006

ORIĞINAL

			1 - For State Registrar		of Marylan			of Health of Death			leg. No.	006	14435
	Physici	an	Decedent's Name (First, Middle,	Last)				G-22		Date of Dea Month	Day	Year	3. Time of Death 3:38 P M
	/Medic	al	4a. Facility Name (If not institution,	nive street and nu	mher)		4h City T	GREG Town, or Location	- 1	MAY	40.00	2006 ounty of Death	3.381 M
	Examin	er	THE JOHNS HOPKINS		imbery			HORE LITY	OI DOGIII		40.00	ounty or Beaut	
	Funeral			6. Sex	7. Age (In yrs.	ast birthday)	If Under		r 24 Hrs. Min.	8. Date of Birth (Month, Day	Your	9. Birthp	lace (State or Foreign
	Director		250-62-0402	1 X M 2□ F	56	Yrs.	Months	Days Hours	Min.	05-29-19			Carolina
	and		Usual Residence of Decedent 10a. State 10b. County	1	10c. City	y, Town or Lo	calion		 .			1	0d. Inside City Limits
	Maryl f eho	tor	MD 1	J A			Balt	timore					1X Yes 2 □ No
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow fra Madical Examirat matt ke melified at	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Citize	n of What Cour	ntry?
	th with	al D	501 E. Preston St	reet				21	202			USA	
	r dea	Iner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U. orces?	S. 13. \	Vas Decede Yes, speci	ent of Hispanic O fy Cuban, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)	14	Race - Americ Black, While,	
9	s afte	by Fu	1 Mover Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Gi	ive **		I □ Yes 2					pecify:	
3	hour		15. Decedent'	Year or D	Jates:	16a, Deced	lent's Usual	Occupation			16b. Kind	Bla of Business/Inc	
N O	n n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	1-4or 5+)	(Give life. L	kind of work	k done during mo e retired)	st of worki	ing	TOD: TUTO	0. 50011000	30307
7	giene giene er tha	Com	3	College (17401 37)		Labore	r				Roofing	
מום	be file tal Hy d oth	Be	17. Father's Name (First, Middle, L	.ast)				18. Moth	ner's Name	e (First, Middle,	Maiden Su	ımame)	
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Iteme 23a or 28a-f ehow empty or other treumatic event, the Medical Examination and the notified at ODGe.	To	Levi Gregg			T				e Askin			
Mar	d 2 sh th and 7 le π treum		19a. Informant's Name/Relationsh			19b. Mailin		(Street and Numb W. North A					Code)
D)	1 and Healt tam 2		Luepen Wallace/ Sis	ster	20b. P	lace of Dispo	sition (Nam	e of		т.	<u> </u>	tion - City or To	wn, State
altimor	ages ant of it: If it		1		State	emetery, cren 11awn Ce	- '		05-13-				
	ortar		21. Signalure of Funeral Service L		WOOL			Address of Faci		00	WOOGIA	awn, MD	
Ŏ	Departing Department of the particular in the pa		Sumerla	Jones		W	ylie F	meral Hom	e 638	N. Gilmor	Stree	et Balto,	MD 21217
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that	caused the death	n. Do not ente	er the mode	of dying, such a	s cardiac o	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Pu	MONARY E	DEMA							Onset and Death
	/Medical Examiner		resulting in death)		(or as a consequ			<u> </u>					
	*	-	Sequentially list conditions,		(or as a consequ								10 YEARS
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		cular Di								15
·	execunation and ial-tra	Exa	that initiated events resulting in death) Last	0.	(or as a consequ								15 YEARS
Š,	sate be executed physicien and the burial-transit	Ical	11	d									
8	certificate be executed nding physicien and use as the burial-transit	Med	IF FEMALE:										
Š	w requires that the death certific: been signed by the attending pl should be detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregna birth 2 Petal	death 3	Ectopic pre				230	d. Date of delive Month	ory Day Year
5	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg	nant at time of de lown	eath 5∟	Other (spe	cify)				77.0.11.1	
ŗ	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ns contributing to d	leath but not resu	ulting in the ur	nderlying ca	use given in Part	L	23e. Did to	bacco use	coninbute to th	ne cause of death?
corus,	puires n sign uld be	d by	CHRONIC DOSTULLIN	E Augusac	y DISEASC		_			1 🗆 Y	es 2 🕱 1	No 3 ☐ Prob	ably 4 □Unknown
3	s bee	Completed			•					24a. Was a		24b. Were auto	psy findings available
C	The lay	E O								autops perfor	med?	death?	npletion of cause of 2□ No
2		Be C	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only or			
> 5	Attending Physician: r death. sctor: After this certific by the funeral director,	2	1 ☐ Yes 2 🕱 No			ER/Outpatien				me 5□Resid			<i>ı</i>)
	After I	lon	27. Manner of Death 1 Natural 5 □ Pending		of Injury oth, Day Year)	28b. Time of Injury		lc. Injury al Work?		28d. Describe h	ow injury o	occurred	
VISIOII	death death stor: / the	Icat	2 Accident investigation 3 Suicide 6 Could no	ot be 290 Place	e of Injury - At ho	me farm str	M factory	1 Yes 2		28f Location /S	treet and N	Number or Rura	I Route Number,
<u> </u>	effer Direction of the point of	Certification:	4 Homicide determin	build	ling, etc. (Specify	()	301, Idolo1y,	Unios		City or Tow	n, State)	Va	, riodio rambor,
	To the Hospital or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the	e best of my kno- pasis of examinal	wledge, death tion and/or inv	occurred a	it the time, date a in my opinion, de	nd place, a	and due to the c ed at the time, d	ause(s) an late and pl	nd manner as st ace, and due to	ated. the cause(s)
	omple	Med	29b. Signature and title of certifier	Sid Hai			29c.	License number		2	29d. Date s	signed (Month, i	Dey, Year)
)	4		> Sush N	BOILAL DOC	TOR		RS	ES-000			4A4 6	,2006	
6			30. Name and address of person w										91
0	₩		STUART AMATEA	J, THE JOH	NS HOPKIN	S HOSPI	TAL, GO	O NORTH	WOIFE	STREET,	BALTI	MORE, MA	RYLAND 21287
	Sta		31. Date filed (Month, Day, Year)	32.	egistrar's Signa	Three London	Well !						
	Registr	ar	MAY 0 9	2006	18450 F	1							

DHMH 17 Rev 1/2001

		Decedent's Name (First, Middle, Last)	. Date of Death Month D	ay Year 3. Time of Dea
Physician /Medical		a. Eacility Name (If not institution, give street and number), 4b. City, Town, or Location of Death	Apr. 30	County of Death
Examiner	46	Johns HOPKINS. Hospital Rattimore		NIA
uneral	5.	Social Security Number 6. Sex 7. Age (In rs. last birthday) If Onder 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	9. Birthplace (State or Fo. Country)
irector	6	729-46-3149 1 M 200 F 77 Yrs. Months Days Hours Mill.	04/26/1	929 WEST-Ind
MOU THE	-	Oa. State 10b. County 10c. City Town or Location		10d. Inside City Li
be notified Director		Md. NA BATTMORE	100	1 ☑ Yes 2 ☐
a or 2 bank	1	0e. Street and Number 4800 Yellowood Ave. 10f. Zip Code	109. 0	itizen of What Country?
r Items 23s irrer must Funeral	1	1. Marital States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Marital States 14. Was Decedent of Hispanic Origin? (Specific Marital States 15. Was Decedent of Hispanic Origin? (Specific Marital States	iy Yes or No-	14. Race - American Indian, Black, White, etc.
° 5 >		1 Never Married 2 Married 1 Yes 2 No Specify: To	, ,	Specify: RIA 6 16
"natural", o		15 Decedent's Education 16a Decedent's Usual Occupation	AICAN 16b.	Kind of Business/Industry
	. -	(Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	N	ursing
other than vent, the Man		12 NURSES HIGE	First Middle Maids	+GENCY
even H	1	Successed 1/51.	TE /	on Sumanie)
and Menta is marked sumatic ex		19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F	Route Number, City	or Town, State, Zip Code)
123		Sylvia Dillon 25/2 BAYKAL DR	. KISSI	mnee, FA.
0	2	1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory of other place)	e 20c.	Location - City or Town, State
Department Important: i any injury o once.	15	· 4 Donation 5 Other (Specify) Woodlawn (FMFTERY 5/6/2	DOG BA	LTO, Md.
Department in poor	1,	21. Signature of Funeral Service Licensee	ones	Alto Md 212
	-	1817 18 18 18 18 18 18 18 18 18 18 18 18 18	VU TTU C	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or i	respiratory arrest,	Approximate Interval Between
ysician	111	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or is shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	respiratory arrest, omyopathy	Interval Between
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ysician Medical caminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions b.	respiratory arrest, prinyopathy	Interval Between
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Itending physician and my or use as the burial-transit cansit lan/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 W No 2 W No 2 W No 2 2 2 2 2	respiratory arrest, prinyopathy	Interval Between
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us been signed by the attending physician and use as the buriat-transit up pleted by Physician/Medical Examiner	F	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	23e. Did tobacc 1 Yes 24a. Was an autopsy performed	23d. Date of delivery Month Day Year 2 No 3 Probably 4 Unkr 24b. Were autopsy findings avar prior to completion of causi death?
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Is after death. In Director: After this certificate has been signed by the attending physician and in Director. After this certification, page 2 should be detached for use as the burial-transit in Director. Page 2 should by Physician/Medical Examiner.		Cardicologo Cardicologo	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	23d. Date of delivery Month Day Year o use contribute to the cause of deatt 2 No 3 Probably 4 Unkr 24b. Were autopsy findings ava- prior to completion of cause death? 1 Yes 2 No 0 Other (Specify) jury occurred and Number or Rural Route Number, ate) (s) and manner as stated. and place, and due to the cause(s)

ORIGINAL

			State of Maryland / Department of Health and M	Mental Hyg	giene	111107
		_	1 - State Registrar Certificate of Death		lag. No	10 14431
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day	3. Time of Death
	/Medic	al	KAYMOND HAWKINS	5		06 12:35 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Tourn, or Location of Death		4c. County of	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		LTIMORE 9. Birthplace (State or Foreign
	Funeral Director		213-12-4075 19M 20 F Yrs. Months Days Hours Min.	(Month, Day	Year)	MARY/AND
			Usual Residence of Decedent	1113	//110	111710917100
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar.	ţċ	MD HARFORD JUPPA			1 ☐ Yes 2 ☐ No
	th the	lre	10e. Street and Number O 10f. Zip Code		10g. Citizen of Wh	nat Country?
	23a (Funeral Director	2408 Kunney KD. 21085		USA	+
	- dea	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	or it	by Fu	1 □ Never Married 2 □ Married 1 □ Fos 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify:		Specify:	WHITE
Ö	within 72 hours after death with the Maryland ene. tten "ratural", or items 23a or 28a-f show the Mavical Examiner must be motified at	d b			16b. Kind of Bus	WATTE
<u>ب</u>	n 72 n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired)	king	-	LOATED
7	with ene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER			FINEER
D	i filed Hygi other snt, I	Be C		ne (First, Middle,	Maiden Surname	
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Maryland 21215-0036	shou and N		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus			
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene the "natural", or Items 23a or 28a-f show then 17 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent. The Maryleal Exemities must be multilised at		KEITH HAWKINS - SON 2408 KONNEY KO	· Jop		0 21085
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Ш	205 20		May to. Billy. EVANS FUNERAL	MAPEL	- TARK	CuillE MD 21734
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between Onset and Death
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Division of Vital Records,	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow		
	spite		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the c	ause(s) and man	ner as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, o	date and place, ar	nd due to the cause(s)
	Within To 11	Σ	29b. Signature and title of certifier 29c. License number		-	(Month, Day, Year)
	λ		A CU ATIVITY PHY Sveitin DS 3	842	May	182008
	mx,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	22	24	1 8 2006 more 2/259
	,			505	pall.	111012 -103/
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Russell Hall 10:35 PM May 5, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Lutherville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07/09/1922 5. Social Security Number 9. Birthplace (State or Foreign Country) NJ 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F 83 Yrs. Director 213-16-6606 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, it a Madical Examinar must be notified at 1 ☐ Yes 2 TNo Directo MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 44 Lyndale Ave USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∰Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Caucasian ģ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry General Motors Elementary/Secondary (0-12) College (1-4or 5+) Inspector 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Miller Hall Julie Thorne 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Waitz/Daughter 925 Lake Forest Pkwy Louisville, KY 40245 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Chesapeake Crematory 9,2006 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives and Sue 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred at or Atter.

Just after death.

Aral Diractor: After

No the for 1 X Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2006 Registrar MAY 0

Please Type or Print in Black Indelible Ink

Konnie Harris	1- For State Registrar	of Maryland / Depar Cert	ificate of Death	iù ivientai m	/gierie Reg.	No. 2000	
Physician/ Medical Examine	Decedent's Name (First, Middle,La.		На	rris	2. Date of Death Month D April 23, 200	ال الله منه	3. Time of Death
Weulcai Examine	Ronnie 4a. Facility Name (if not institution, gir	Edward ve street and number)		or Location of Death	April 23, 200	4c. County of Death	
	638 Frederick Road		Catonsville			Baltimore Cou	
Funeral Director		7. Age (In yrs. las	st birthday) If Under 1 Ye Yrs. Months Da		8. Date of Birth(1	MM/DD/YYYY) 9. Birl 7 54 Foreig	
an y	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
aryland 8a-f show any at once.	MD NA	Bal	timore				1 X Yes 2 No
rith the Maryland s. 23a or 28a-f show c. notified at once.		oga Street #	10f. Zip Code	21201	10g.	Citizen of What Cour	•
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Merkral Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married	1 Yes 2 X No	If Yes, specify Cuba	an, Mexican, Puerto		White, etc.	can Indian, Black,
urs after tural", uniner	3 Widowed 4 Divorce	If Yes, Give Year or Dates: nly highest grade completed)	1 Yes 2 X N		ork done 16	Specify: Sb. Kind of Business/i	-345
6 72 hou an "naters al Exs	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working lif	e. DO NOT use retir	red)	Various	Tobs
5-0036 iled within 72 hours Hygiene. I other than "natur the Me is al Exam Completed	12th grade 17. Father's Name (First, Middle, Lasi	na	Laborer	18 Mother's Name	(First, Middle, Mai		
21215-(21215-(Mental Hyg marked oth ic event, the	Herbert Harris			Jeanet	te Scov	en s	
e, MD 21 1 and 2 should Health and Me item 27 is man r fraumatic ev	19a. Informant's Name/Relationship (Jeanette Harr:	s-Mother	19b. Mailing Address (Stree 751 North				
of Heal	20a. Method of Disposition 1 Burial 2 Cremation 3		ace of Disposition (Name of commentary or other place)	,		0c. Location - City or	. ,
·= . # # P	4 Donation 5 Other Specification Signature Funeral Service Lice	; M	It. Carmel		5/06	Baltimor	e, Md
Balt permit Depart Impor Injury	Novald	() Stundt	22. Name and Addres March F/ 4300 Wab	ash Ave	, Balti	more, Md	21215
Physician /Medical	23a. Pa (I. Enter the disease, or com f jure. List only one cause on e	ach line.				shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease a or ondition resulting in death)	Alcohol and narco		and cocain	e use		Deau
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876(tificate ng phy as the b	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy Petal death 3	Ectopic pregna		23d. Date of delivery Month	y Day Year
box 68760, the death certificate be executed by the attending physician and oched for use as the burial - transit	past 12 months?	4 Pregnant at time of death	5 Other (Specify)				
that the de led by the detached is			sulting in the underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach briffication: To Be Completed by P	·				1 Yes		ably 4 🗹 Unknown
Records, The law requires fircate has been significate basen significate basen significate and been significated.					24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
tal Rec			26 Place	e of Death (Check o	1 ✓ Yes 2		s 2 No
Vital ysician his cert directo	examiner?	Hospital: 1 Inpatien 2 E	ER/Outpatient 3 DOA	Othor:		sidence 6 🗸 Other	: Scene
Ing Ph	27 Manner of Death	28a. Date of Injury (Month, Day,Year)		ury at Work?	28d. Describe how	injury occurred	
Sior Attend r death rector: by the	2 Accident Pending Investigat	28e Place of Injury - At hon	End 2:20 PM	Yes 2 X No	unk 28f Location (Stre	et and Number or Ru	ral Route Number City
Division o spital or Attending tours after death, neral Director: Aft filled in by the fure Certification:	3 Suicide 6 X Could not determine	be	•	3,	or Town, State Catonsvil	e) 638 Freder 1e. MD	ral Route Number, City ick Road
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi-Medical Certification: To Be Completed by Physician/Medical Ex		ian: To the best of my knowledge r:On the basis of examination and and manner stated.					
£ 3 £ 8 2	29b. Signature and title of certifier	1		se number	· ·	9d. Date signed (Mor	nth, Day, Year)
	7 headen U.	King mo		.M.E.		April 24, 2006	
	30. Name and address of person who Theodore King MD. As	completed cause of death (Item 2 sistant Medical Examiner		altimore, MD 21	1201		
State	111 11 11 11	2006 32. Resistrar's Signature	K Kinks				
Registra		1-2000	-				

06-02996* William Harp Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1-For State Amend Item#5 per FH G855er6f/d99/06Death Reg. No ent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month May 3, 2006 0900 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Northwest Hospital Randallstown **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) Funeral Days Director 2 Ϊм Usual Residence of Deceden 10d. Inside City Limits 10b. Cour 10c. City, n or Location Baltimore Catonsville Yes 2 No 28a-f show 11 WILL death with the Maryland Director 10f. Zip Code 2122 10g, Citizen of What Country Rolling Road or items 23a Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces' White, etc. Married 2 X No Pages I and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", o If Yes, Give Yea Divorced Yes 2 X No specify. Specify. 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 a Be 2 tou 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location -City or Town, State crematory or other place or other 2 3 Buria! Removal from State ortant: Othe Approximate Interva 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** en Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED ending physician use as the burial -The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnance 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ No 3 Probably 4 ✔ Unknown Seizure disorder, Dementia, Chronic Obstructive Pulmonary Disease Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other 4 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 V Yes After 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural 1 Yes 2 Pending Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 4, 2006 30. Name and address of person who completed cause of death (Item 23a) 1 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year) 32: Registrar's Signature State MAY 0 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4-2006 tenderson /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month Day, Year) 10-20-1921 Birthplace (State or Foreign Country) (ast birthday) **Funeral** Days Months Min 1 M 2 F Yrs. Director Usual Residence of Decedent 10a. State County own or Location 10d. Inside City Limits 10b or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Kesvi more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 Yes 2 No 1 Never Married 2 Married 1□Yes 2⊅No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify þ 3 Widowed 4 □ Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working ta, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene Department of Health and Mental Hygiene Important: If Item 27 is marked other than "n. any injury or other traumatic event. If a Mental Dange. ry (0-12) College (1-4or 5+) ath ar 18. Mother's Name (First, Middle, Maiden Sumame, 17 Tather's Name (First, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Pint) MD 21208 20b. Place of Disposition (Name of cemetely, crematog or other p 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Poor 21. Signature of Fundial Service License MD 2113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sur shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Myoinder Physician /Medical Due to (dr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed the attending physicien and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE; 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetaf death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 Probably Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed? After this certificate 2 No 1 Yes 2000 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) -55.5 feed Cooping Other: 4 Nursing Home 5 Residence 6 Corner (Specify) Hospital: 1 Inpatient 2 No ٩ 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation Natural 1 Yes 2 No death. 2 Accident 24 hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie 30. Name and extracy 1/5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2006 Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] 🛭 🕤 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:20 P M May unice 2006 /Medical 4a Facility Name (If not institution, give street and number) of Death Examiner randalls ltimore jienesi's town Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State Country) **Funeral** Days 213-18-6316 1 M 2 F Director Usual Residence of Decedent with the Maryland 10a. State Town of Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show If a Medical Examinational be notified at 1 Yes 2 10 Director estmins 10g. Citizen of What Country? 10f. Zip Code USA 701 21157 Coac Funerai filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian 11 Marital Status Black, White, etc. Yes 2 f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT user retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) eache yrs 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperiment of Health and Mental Hy Important: If Item 27 is marked oth any liury or other traumatic event 2008. Mother's Name (First, Middle, Maiden Surname) Be 100 19a. Informant's Name Relationship (Type, Frint) 19b. Mailing Address (Street and Number ty or Town, State, Zip Code) iral Foute Number 20b. Place of Disposition (Name of cemetery, grematory or other) 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funera Service Licens ee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Artenoscienti Cordiolascy lar dispose /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence on Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-fransit Due to (or as a consequence of) Box 68760. Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year signed by the at the detached for 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 20No 1 Yes : Affer this certifical funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 💢 No 2 ER/Outpatient မ 1 Inpatient 3□ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: Injury at Work? 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 x artifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the eause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2% Cartifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30115 51416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 531 old ct Rd Randollsmun mo 21133 Ohlok pehai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2006 Registrar MAY 0

			1 For State Registrar	State o	of Marylar		artment of H rtificate of I			ene	6	
	Physic /Med		Decedent's Name (First, Middle, La Ronald	st)			Higgs		2. Date of Death Month	Day	Year 006	3. Time of Death 3, OOH M
	Exami		4a. Facility Name (If not institution, give 600 d SAMA)	-/	tospis	Cal		Location of Death		4c. County		
	Funeral Director		5. Social Security Number 6. S 218-68-7264 Usual Residence of Decedent	Sex 1(XM 2□ F	7. Age (In yrs.	last birthday, Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		9. Birthp Coun	place (State or Foreign ntry) Md
	laryland show	_	10a. State 10b. County		10c. Ci	ty, Town or L					1	0d. Inside City Limits
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4116	27275-0036 d within 72 hours af giene. r than "natural; or the Medical Exem	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired,	turina most of worki	ing 10	6b. Kind of Bu		lustry
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¥.	Maryland d 2 should be file th and Mental Hy ?7 is marked oth traumatic event	2	Richard Redd 19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street a	Pauline and Number or Rura		City or Town,	State, Zip	Code)
1	Heal Heal tem 2		Mildred Knights 20a. Method of Disposition 12 Burial 2 Cremation 3		20b. F	Place of Dispo	3605 Mor	nterey Rd	., Baltin	nore, M.	Id. City or To	21218 wn, State
:	Baltimore, permit. Pages 1 s Department of He Important: if item eny injury or othe		4 ☐ Donation 5 ☐ Other (Specification of Control of Co	-		22	armel Cem. Name and Addres March F. H	s of Facility	Balti	Dundalk Lmore, E. Nort	Md.	21202
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	with ti	Funeral Directo	100. Street and Number 707 Camberley Ci	rolo			10f. Zip	204				10g. (What Count	ry?	
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06-02837 Susan Estes

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State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			,	Cer	tificate		ath	G 1110111	ω <u>,</u>	J	Reg. No.	201	US	1 1 1 1
Physici Medical Exami		Decedent's Name	(First, Middl	e,Last)								2. Date of Dea Month		Year		3. Time of Death
wedicai =xami	ner	Susaii Lea	san Lea He1ms-Estes acility Name (if not institution, give street and number) 4b. City, Town 714 Light Street Baltimo cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under-								. Darette	Month April 26,	2006			1950 hrs
				n, give street an	d Halliber)					Location of	Death		40	County of D. Baltimo		
Funeral		5. Social Security N	umber	6. Sex	7. Age	(In yrs. la	ast birthday) If (Inder 1 Yea	ar If Under	24Hrs.	8. Date of B	irth(MM		_	iplace (State or
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Joseph Heli		Last)						Bobbi e		(First, Middle,	Maiden	Surname)		
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Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		20a Method of Disp		3 Remov	al from Sta		Place of Dis			metery,		Date	20c.	Location - Cit	y or T	own, State
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	Σ	29b. Signature and to	itle of certifier	/1///	1				29c. Licens					Date signed (ı, Day, Year)
		XYV	len	10	1				O.C.I	M.E.			Apri	1 27, 2006		
10	Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI						D 242	01								
	ate	31 Date filed (Month, Day Year) 32/Registrar's Signature										_				
Regist		31. Date filed (Month, Day, Year) MAY 0 9 2006 32. Registrar's Signature														

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	Funeral Director		5. Social Security Number 215-16-7337	6. Sex 7. 1 ☐ M 2 🕶 F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I		th ay, Year) 3/1919	Birthplace (State or Foreign Country) MD
70			Usual Residence of Decedent							0, 1010	
Manyla	f ehov	ō	MD Balt	imore	Wind	sor 1					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the	r 28e-	Director	10e. Street and Number		Willa	.501	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen of	
th with	23a o	al D	7803 Kenbridge	Road			21244				States
:1215-0036 within 72 hours after death with the Maryland	of Heelth and Mental Hygiene. Item 27 is marked other then "natural", or Itema 23a or 28e-1 show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Moivorced	If Vec Give	s? XINo	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 270 No	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No uerto Rican, etc.)	Bla	ce - American Indian, ck, White, etc. ^{y:} Black
2-0C	satura Ical E	ted	15. Deceder	nt's Education		Sa. Deced	lent's Usual Occupa	ation			usiness/Industry
21215-0036 d within 72 hours af	hen "r	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of work done of DO NOT use retired nsed Prac			Geriat	ric Care
3 €	Hygie off.	o C e	17. Father's Name (First, Middle,	Last)	2	nrce	ised Flac		Name (First, Middle	. Maiden Suman	ne)
should be	Vental	To Be	Warner Willia	ms					Myers		,
, Maryland and 2 should be file	Heelth and Plem 27 is matching that traums		19a. Informant's Name/Relations Mr. Melvin Abdu		/Nephew	9b. Mailin 827	g Address (Street a	nd Number or gton Av	Rural Route Numb enue, Apt	er, City or Town,	State, Zip Code)
E Se	ant: If Iten ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			tery, cren	sition (Name of natory or other place	θ)	May 11 2006		City or Town, State
Balti Permit	Department of Important: If It any injury or one.		21. Signature of Funeral Service	Licensee	M00980	22	Name and Address remation 3 717 Green	s of Facility and Fune Pasture	eral Alter es Drive 1	natives Baltimore	e, Maryland 21286
//	Aphysician and serial-transit serial-transit serial-transit serial-transit serial-transit serial ser	dical Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sulfand Due to (or c.	n line. OUTO CA as a consequence MENT as a consequence as a consequence	n n n n n n n n n n n n n n n n n n n	. 1		hage	11631,	Approximate Interval Between Onset and Death
. BOX 6	y the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)				te of delivery inth Day Year
ecords, P.O law requires that the	eng b ed	ρ	Part II. Other significant condition	ons contributing to death	n but not resulting	in the un	derlying cause give	n in Part I.	23e. Did to		nbute to the cause of death?
r e	certificete hes been si irector, page 2 should	Completed								an 24b. Vosy	Were autopsy findings available prior to completion of cause of death?
OT VITAL Physician: T	certific rector,	Be	25. Was case referred to medica examiner?	Hospital:	0.01		Othe		Death Check only o		
_	n. After this funeral di	7: To	1 ☐ Yes 2 € No 27. Manner of Death	1 ∐ Inpa 28a. Date of Ir	njury 28b	Outpatient . Time of	3 DOA 28c. Injury Work	4 Comsing	Home 5 Resid	dence 6 Oth	er (Specify)
VISION	tor: After	atloi	1 Denural 5 ☐ Pendir 2 ☐ Accident investi	gation	Day Year)	Injury		? ′es 2 □ No		,	
UIVISION tel or Attanding	s arren de al Directo ad in by th	Certification;	3 Suicide 6 Could 4 Homicide determ	lined 286. Place of I	Injury - At home, etc. (Specity)	farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb vn. State)	er or Rural Route Number,
DIVISION To the Hospitel or Attance	he Funaral Dir he Funaral Dir pletely filled in	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the bes Examiner: On the basis and manner	OI OXAIIIII alion a	ge, death and/or inv	occurred at the time estigation, in my op	e, date and pla inion, death oc	ice, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
Total	To the compl	×	29b. Signature and title of certifie		mo.	mo	29c. License	number 5641	4	29d. Date signed	260 G
	2	- 4	30. Name and address of erson Tocelyn N-E	who comple of cause of	death (Item 23a	(Type, F	og Libert	y Road	1, Randa	1/stown	200 G 1, MD 21/33
	Star Registra		31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1000					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Johnson ma /Medical 2006 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth more N/A7. Age (th yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2XF 219-10-7517 89 Director Maruland Dec. Usuel Residence of Decedent init. Peges 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural," or items 28a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4606 Asbury Avenue 21206 u. s. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ş 3 Widowed 4 □ Divorced Year or Dates: White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
7th Grade College (1-4or 5+) Retail Sales Read's Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James M. Scott Mary E. Isett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Johnson (Dghtr) 4606 Asbury Ave., Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department important: If any injury or Moreland Memorial Park 5/6/06 Baltimore, Maryland 22. Name and Address of Facility Schimunek Functual Home Inc. 21. Signal re of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 ang 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Attending Physician: The lew requires that the deeth certificate be executed the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of weth? efter death.

I Director: After this certificete has been signed by I d in by the funerel director, page 2 should be detact 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ð Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 TNo investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add 695 of person who completed cause of death (Item 23e) (Type, Print) 32. Registrar's Signature MAY 0 31. Date filet (Month, State 9 2006 0 Registrar

Examiner **Funeral** Director 28a-f show

termon Jensen

Physician

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760 P.O. the Records, has Division of Vital this After

HERMAN HENRY JENSEN, JR. Ma 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Specially 7. Ago HOSP Universit N/AIf Under 1 Year If Under 24 Hrs. Social Security Number On yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 1 € M 2 □ F 219-22-7050 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Director Baltimore N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3505 Woodring Avenue or Items 23a 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Highway Administration Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Henry Jensen. Sr. Hele Antoszewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Mildred E. Beese (Sister) 310 Thornhill Road, Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
21. Signal Fundal Ser Libers e Martin D. Lawson Dulaney Valley Mem Grdns 5/11/2006 Timonium, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 York Road, Baltimore, Maryland

21 212

Approximate Interval Between Onset and Death

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death IN THA CRAWIAL Immediate Cause (Final Pnysician RUGED ONE MOWITH disease or condition resulting in death) /Medical Due to (or as a consequence of) CENEBRU UNSCULAR ONE MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð URIN MAY mure . INFECTION 1 Yes 2 No 3 Probably 4 Wunknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: • Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: s after dec. 1º Anatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Di 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0061765 well MAY 06 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EBEN FREN QUAINTE UM 3350 WILL KENS ANT #307 BACTIMENT MD R1229 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 0 9 2006 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Month

8100 PM

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day urtis Johnson 12:17 PM May 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown
If Under 1 Year If Under 24 Hrs. Northwest Center Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07-26-1930 Birthplace (State or Foreign Country) Days Months 1 XM 2 ☐ F Hours 223-34-0247 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2309 Chelsea Terrace TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify. 3 ☐ Widowed 4 X Divorced **Black** 16a. Decedent's Usual Occupation UNKNOWN (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unknown 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charlie Lee Johnson Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherna Barksdale/ Guardian 10 N. Calvert Street Baltimore, MD 21202 20a Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-09-06 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Surela Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) brain Anoxic Due to (or as a consequence of): centra nervous system Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last rolonged Due to (or as a consequence of): systolic cardiac Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 VUnknown marasmus 24a. Was an

Physician /Medical Examiner

certificate be executed

Box 68760,

P.0.

Records,

Division of Vital or Attending Physician: **Physician**

/Medical

10a State

Director

Funeral

þ

Completed

Be

Examiner

Funeral

Director

ir than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after

and Mental Hygiene.

f Health

Department of h importent: If ite eny injury or ot once.

3altimore, Maryland 21215-0036

physicien and s the burial-transit as signed by the attending d be detached for use as been certificate To the Hospital or Attanding Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. this

Examine Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown ģ Acute rend Completed Adult Vascular dementia 25. Was case referred to medical examiner? Be 1 Yes 2 No ဥ 27. Manner of Death Certification: 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

Metabolic bone disease 26. Place of Death | Check only one

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

autopsy performed? 1 ☐ Yes 2 W No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical

State Registrar

4 Homicide

1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Soston

D28462

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northwest Hospital

Center Randallstown, Maryland

31. Date filed (Month, Day, Year)

32. Registrar's Signature 2006

			1 - For State Registrar	State of Maryla		artment of F			giene Reg. No. 2	006	la la E
п	Physic	ian	Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day	Year 3. 1	Time of Death
	/Medi		Charles Clarenc					May	5, 200		:10 P M
	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	h	4c. County of	of Death	
			4400 Quaker Hill 5. Social Security Number 6. Se		- Jana bint da 1	Havre	De Grace			rford	
	Funeral Director			XM 2□F 7. Age (in ya	s. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day	/, Year)	9. Birthplace (Country)	State or Foreign
			Usual Residence of Decedent	09				Sept. 2	3,1916	Minnes	ota
	yland now		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. ln	side City Limits
	a-f.s	cto	Maryland Harford		Havr	e De Grac	e			1 [Tes 2√TNo
	ith the Marylar or 28a-f show	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	ath w	ie	4400 Quaker Hill	s Ct		21078	}		U.S.A.		
	r des	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race	- American Inc.	lian,
36	or h	by Fi	1 Never Married 2 Married	1 Styes 2 □ No If Yes, Give		1 ☐ Yes 2 ᡚ No	Specify:		Specify:	, wille, etc.	
21215-0036	72 hours after death with the Maryland 'natural', or itams 23a or 28a-1 show dical Examiner wat be notified at	d b	3 XWidowed 4 ☐ Divorced	Year or Dates:						Whi	te
15	n 72 nai	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of Bus	iness/Industry	
12	with ene. than	m _C	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		achinist	2)		Aviati		
	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or flams: aumatic event, If e Medical Examiner.	(D)	17. Father's Name (First, Middle, Last)		TIC.	aciiinist	18. Mother's Nan	ne (First, Middle,			
Maryland	lid be lental ked ic ev	To B	John Franklin	Jones			Joseph			,	
ary	shound M	-	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event. If e Modical Examiner out be notified at once.		Karen Schreiber/	Daughter		00 Quaker			e De Gra		21078
Baltimore,	as 1 a		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date	20c. Location - C		
Ĕ	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	tomovar irom otato	tro Cre		05/09	/2006	Baltimor	e MD	
a	permit. Departn Imports any inju		21. Signature of Funeral Service Licens			Name and Addres	ss of Facility	72.000			
ω_	88 5 8	11	Jessie He	2		6415 Be	lair Roa	unerai n d Balti	ome, inc more MI	21206	5
	/Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying cause (Disease or injury		quence of):	heart f	ailure			Onse	al Between than death the second seco
P.O. Box 68760,	death certificate e attending phy id for use as the	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	al death 3 death 5	Ectopic pregnancy Other (specify)			23d. Date Monti		Year
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	iderlying cause give	en in Part I.	23e. Did tol	pacco use contrib es 2 kNo 3	ute to the caus	
S	w requir been si should	iete						24a. Was a	245 146		diago evelable
Vital Record	The ate h page	Completed						autops	y pri- ned? de	ere autopsy find or to completion ath?	n of cause of
₹		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		3□ DOA Othe		h (Check only on			
	ding h. After funer	ertification; To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 - Italianing in	ome 5 € Peside 28d. Describe ho			
DIV	Dir.	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)	eet, factory, office		28f. Location (St. City or Town	reet and Number , State)	or Rural Route	Number,
	S C D S	edical	29a. Certifier Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my kn- ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tim estigation, in my op	e, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manr ate and place, an	ner as stated. d due to the ca	use(s)
	To the h within 24 To the F complete	2	29b. Signature and title of certifier			29c. License		29	d. Date signed (Month, Day, Ye	ear)
1			pedent The	lle m		2000.	42050		5/2/01	5	
	1	ı	30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, F	Print)					
_	9		Dr. Prashant Shu	kla 15 S. Pa	rke St.	Suite 4	00 Aber	deen MD	21001		
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 0 9 2008	2. Registrar's Sign		L.				_	

			1 - For State Registrar		Marylar		artment of I rtificate of			Rag	ene	116	14452
	Physici /Medic		1. Decedent's Name (First, Middle, Las Joo H. Kim	t)						2. Date of Death Month 05-05-2	Day 006	Year	3. Time of Death 10:10 m
10	Examir		4a. Facility Name (If not institution, give Randolph Hills Nu				4b. City, Town, Whe	or Location o	of Death			y of Death	-
Ī	Funeral Director		5. Social Security Number 6. S		7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth		9. Birtho	olace (State or Foreign
	e Maryland 8a-f ehow	ctor	Usual Residence of Decedent 10a. State	gomery		ty, Town or Lo	Spring					1	10d. Inside City Limits ★☆Yes 2 ☐ No
036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "netural", or items 23e or 28e-f ehow event, the Modiral Examinar must be muilied at	by Funeral Director	10e. Street and Number 4001 Post Gate To 11. Marital Status 1 Never Married 2 Marned 303/Vidowed 4 Divorced	12. Was Dece- Armed For 1 Ues If Yes, Give Year or Da	dent Ever in U ces? 2∕2∏No	.S. 13.	10f. Zip Code 20f Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑No		gin? (Spec , Puerto P			ce - Americ	can Indian,
Maryland 21215-0036	ed within 72 ho rgiene. In the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1- 5-1	4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	t of workin	g 16	Hote		dustry
yiand	Q 22 20 9	To Be	17. Father's Name (First, Middle, Last) Chang Hee Kim					Sa	ing He	(First, Middle, Ma			
	is 1 and 2 should of Health and Men item 27 le marke other treumatic		19a. Informant's Name/Relationship (1) Chu1 H. Kim/son 20a. Method of Disposition	урө, Print) 	20h F	5409	ng Address (Street Calvary	Post	Dr.	Arlingto	n TX	76017	
saitimore,	Page ment c ant: if ury or		1 Reurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral 96 yice / Coper)	tate	stland	matory or other pla Memoria	1 PK	05-09	9-2006		as, T	
g	Departition of the control of the co		23a. Part1. Enter the disease, or comp	mann	M003	82	Name and Address Metrocres 1810 N.	st Fun Perry	eral Rd. (<u>Carrolto</u>	n TX	75006	
8/60,	bhysician and physician and physician and physician and physician and the physician and physician an	al Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneu Due to (c	imonia or as a conseq or as a conseq or as a conseq	uence of):	5. 110 11000 51 571		Sardia o		5		Approximate Interval Between Onset and Death
C. BOX 6	ath certific ettending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta int at time of d	Ideath 3	Ectopic pregnanc	y				ate of delive	ery Day Year
7	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of Cerebral Infaret		ath but not res	ulting in the u	nderlying cause gr	ven in Part I.					ne cause of death?
VItal Records,	The lar	Completed	Alzheimer's Dise	ase						24a. Was an autopsy performe 1 ☐ Yes 2√2	id?	death?	psy findings available mpletion of cause of
	rsician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∑∑No	Hospital:	patient 2	ER/Outpatien	t 3□ DOA Ott			(Check only one) e 5 ☐ Resident		nos (Sanah	
sion of	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ation; T	27. Manner of Death 1	28a. Date o (Mont/	Injury , Day Year)	28b. Time of Injury	28c. Inju Wo		28	8d. Describe how			7
DIVISION	ital or Attures after de rai Directured in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place	of Injury - AI ho g, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28	Bf. Location (Stree City or Town, S	et and Numi State)	ber or Rura	l Route Number,
	the Hosp in 24 hou the Fune apletely fil	ledicai	29a. Certifier (Check only one) Certifying Ph	ysician: To the iner: On the ba and mann	sis of examina	wiedge, death	vestigation, in my	opinion, deat	d place, ar th occurre	d at the time, date	and place,	and due to	the cause(s)
		M	29b. Signature and title of certifier	Pag	al	m		2261		290	05-0	6-200	
	3		30. Name and address of person who a Alan R. Segal MD	- 1	1	, , .	Print) Rd. Sil	ver Sp	oring	MD 2091	.0		
Ė	Sta		31. Date filed (Month, Day, Year)	32 Re	gistrar's Signa	Rure C	wer	•					

		1 - For State Registrar	State of N	/larylar				nd Mental Hy	giene	en pa	
		Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	tificate of l	Jeath	2. Date of De	Reg. No.	Ub	3. Time of Death
Physi /Med		Frank John k	iulczynski					Month	Day 2	Year 2006	4. 45- PM
Exam		4a. Facility Name (If not institution,		r)		4b. City, Town, or			4c. County	of Death	
Funera	al I	Union Memorial 5. Social Security Number 6		ae (In vrs.	last birthday)	Baltin II Under 1 Year		4 Hrs. 8. Date of Bir		/A	non /Ctata as Foreign
Directo		216-07-6392	1 € M 2 □ F	85	Yrs.	Months Days	Hours	Min. (Month, Da	ay, Year)	Mary	ace (State or Foreign ry) Land
land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					d. Inside City Limits
Mary	Ş	Maryland Balti	more		Whi	te Marsh					1 ☐ Yes 2 ☑ No
or 28	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Count	ry?
eath w	Funeral Director	5823 Lytel Roa	d 12. Was Deceden	t Ever in 11	S 42.1		1162			I.S.A.	
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "netural", or itema 23a or 28a-f ehow event, the Madical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	:?] No	H	Yes, specify Cubar	spanic Origin, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)	Specify	e - America ck, White, e	
72 hours aff	eted	15. Decedent's (Specify only highest			(Give	ent's Usual Occupa kind of work done d	urina most a	of working	16b. Kind of Bu		ıstry
within within then.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	00 NOT use retired) Chinist	January most	a working	Automob		
nd 21	Be Co	17. Father's Name (First, Middle, La	st)		Micci		18. Mother	s Name (First, Middle	Manufac , Maiden Surnam		
Iryiand 2 should be filed of Mental Hygi marked other imatic event, 1	To	Zygmund Kulcz	-				Joze				
Ma d 2 s th ar 7 is trau		19a. Informant's Name/Relationship Joseph Kulczyns		,				or Rural Route Numb			ode)
Te 1 an Heal		20a. Method of Disposition		20b. P	Place of Dispos	Sition (Name of satory or other place	Avenu	le, Essex,	MU 2122 20c. Location -		n, State
Pages Pages ment of ant: if its ury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special			dens of	f Faith C	em. 5	16/2006	Baltimor	e Ma	ruland
Saltimore, permit. Pages 1 a Department of Hes important: if item any injury or othe		21. Signature of Funeral Service Lic	ensee		22.	Name and Address	of Facility	Schimunek	Funeral	Home	S
		23a. Part1. Enter the disease, or co	mplications that cause	d the death				Baltimore			Approximate
Physician	1	shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each	ine.						li C	nterval Between Onset and Death
/Medica		resulting in death)	Due to (or as	s a consequ	uence ol):						45 mins
	ē	Sequentially list conditions,	b. Acute	CUCNO	EVY SUY	ratonae					15 mins
nd ansit	Examin	Sequentially list conditions, I any, leading to animodiate cause. Enter Underlying Cause (Disease or injury that initiated events	c. une			SAME					- 5025-CIII
ob exection are citizen are citizen are		resulting in death) Last	Due to or as	a consequ	uence of):	- A.M.C. No.					IS WOOD
ficate be executed physician and sthe burial-transit	dical		d								
The Cords, F.O. BOX of The law requires that the death certifiate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	death 3 🗆	Ectopic pregnancy Other (specify)		(- 232 - 236C)	23d. Date Mor	e of delivery	ay Year
es that gned by	by Ph	Part II. Other significant conditions	contributing to death t	out not resu	ulting in the und	derlying cause giver	in Part I.	23e. Did to	obacco use contr	ibute to the	cause of death?
v require								_ 1_Y	es 2 No	3 Probab	dy 4 □Unknown
The law cate has by page 2 st	Completed								rmed? d	rior to comp eath?	y findings available eletion of cause of
vital sician: certifica irector. p	o Be	25. Was case referred to medical examiner?	Hospital:			Other	1000110	Death Check only or	1100		
To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	H	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju		ER/Outpatient 28b. Time of Injury	28c. Injury a	4 Nursi		lence 6 Othe		
or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4 289. Place of in	ury - At hor c. (Specify,	me, larm, stree	et, factory, office		28l. Location (S City or Tow	itreet and Numbern, State)	ar or Rural R	loute Number,
Hospital 24 hours Funeral stely filled	Medical Co	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o	examinati	vledge, death o	occurred at the time	, date and p	place, and due to the o	cause(s) and mar	ner as state	ed.
To the within To the comple	Me	29b. Signature and title of certifier	and manner st	a.eu.		29c. License i			29d. Date signed		
		> Gauagne mo				ATZ-432	3946		MAY 2	200	6
10		30. Name and address of person who									
St	ate	31. Date liled (Month, Day, Year)	32. Registr	ar's Signati		tospital 1	wo.				
Regist	rar	MAY 0 9 20	U6 /10 gian	a de	Coss	R'S					

_			1 - For State Registrar	State of Ma	aryland /	•	artmen				R	eg. No.	HIIn	14454
	Physici		1. Decedent's Name (First, Middle, La George R. Kerin								2. Date of Dea Month	Day		MALATIN CAR
	/Medio Examin		4a. Facility Name (If not institution, given				4b. City,	Town, or	Location of	Death	riay		County of Dea	7
			Union Memorial					alti					N/	A
	Funeral Director			Sex 7. Age	e (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day Sept 2	, Year)	9. Bi	rthplace (State or Foreign country) yland
	yland yland		10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
	e Mar	ctor	Maryland N/A		Ba1	timo	re							XXYes 2 □ No
	th with the 23 or 28	ai Directo	10e. Street and Number 3939 Roland Ave	nue Apt 91	2		10f. Zip		21211		1	0g. Citi	zen of What C	Country?
980	within 72 hours after death with the Maryland ene. Than "natural", or itema 23e or 28e-f ahow he Madical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes		spanic Origin, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan at all tygiene. All tygiene. All than 'natural', or itema 23e or 28e-f show avent, the Macilcal Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			(Give	DO NOT us	rk done d	<i>urina</i> most i	of working	g		nd of Business	s/Industry
/land	2 should be filed and Mental Hygis Is marked other sumatic avent, III	To Be C	17. Father's Name (First, Middle, Last F. William Car	•							(First, Middle, i e Rebec		,	
Mar	permit. Pages 1 and 2 should by Depermit. If item 27 is marked eny Injury or other treumatic av <u>once</u> .		19a. Informant's Name/Relationship (Sharon Mechling	(Type, Print) Daughte			ng Address Falls				Route Number imore,	-		Zip Code) 21209
Baltimore,	ges 1 at tot He If Item		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	Removal from State	1	itery, cren	natory or o	ther place		Da			cation - City o	
<u>=</u>	it. Pa entmen entent: njury	1	4 ☐ Donation 5 ☐ Other (Special Street of Lice)	(y)	Drui									, Maryland
Ba	Depe Depe Impo		spray H	asperter							Tuneral Ltimore		ne, Inc aryland	21211
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	the death. D	o not ent	er the mod	e of dying	, such as c	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
I	/Medical Examiner		Sequentially list conditions,		d consequence		tino	x1	blee	eal				
	be executed sicien and burial-transit	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pen	ci i	ns.	uff	CIE	ncy					
8760,	icate be ex physicien the burial	icai		a. Tete		co.)	cch	D.YY	<u>u</u> _					
.O. Box 6	the death certif y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pro					2	23d. Date of de Month	elivery Day Year
rds, P	quires that n signed b utd be deta	٥	Part II. Other significant conditions of	contributing to death bu	ut not resulting	g in the ur	nderlying ca	ause give	n in Part I.			oacco u es 2[o the cause of death?
Il Records,	. The law requires that cete hes been signed b page 2 should be deta	Completed									24a. Was a autops perform	y ned?	prior to death?	utopsy findings available completion of cause of
VII	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r		Check only on			
	E 9	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day		Outpation Time of Injury	t 3□ DO	8c. Injury Work	4 LI NUIS	28	e 5 Reside			ecify)
Divisi	tal or Attending s efter death. al Diractor: Afte ed in by the fune	Certification:	3 Suicide 6 Could not be determined	00 00 01 11 1	ury - At home, c. (Specify)	farm, stre	eet, factory				Bf. Location (St City or Town			lural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying PI (Check only one) 1 Medical Example 1	hysician: To the best of miner: On the basis of and manner sta	examination	lge, death and/or inv	occurred avestigation,	at the tim in my op	e, date and inion, death	place, an	d due to the ca	ause(s) ate and	and manner a place, and du	s stated. e to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier Decelyne Keu	AT CHOU	mo		29c	License	number	? e1.	6	9d. Dat	e signed (Mon	th, Day, Year)
	H		30. Name and address of person who	completed cause of de	eath (Item 23a	a) (Type, l	Print)	710	21/20	0	1/1	a .	you	ore. M.D
	' \		JOCELYNE KOLL	atcho u				IVET	Sity	Muri	civaly	,00	SCI # 1 " L	0.0.7.0
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 2005	32. Hegistra	A Signature	Cost	2							

			1 10000	ype of Finit in Blac			•	•	
			For State	State of Maryland / I			Mental Hygie	ene,	1 1 1 200 200
			Registrar		Certificate of	Death	Reg.	No UUD	14455
	Physic /Medi		1. Decedent's Name (First, Middle, Las	Knider			2. Date of Death	2h 201)	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and mymber)	4b. City, Town,	or Location of Dea	N THE	4c. County of Death	7 11 11
	*		<u>Cathinsh</u> 11	e Cemmon	8 16 Fus	sting 1	tre		
	Funeral Director		5. Social Security Number 6. Se	TM aXIE	rthday) If Under 1 Year Yrs. Months Days		(Month, Day, Yo	9. Birth	place (State or Foreign ntry) 'Land
			214-24-8481 Usual Residence of Decedent	85			Oct 12,	1920 Mary	riand
	urylan show	_	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic event, If a Medical Examiner must be notified at	Completed by Funeral Director	MD Baltimo	re Cato	nsville				1 ☐ Yes 2X No
	with t	ā	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	ns 23a	era	16 Fusting Avenue	12. Was Decedent Ever in U.S.	21228	Uinnesia Osinia? (6		JSA	and the state of
40	ter deal	ä	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No	13. Was Decedent of If Yes, specify Cut	pan, Mexican, Puer	to Rican, etc.)	14. Race - Ameri Black, White	
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No	Specify:		Specify:	Co.
21215-0036	72 hours aft "natural", or cheal Exami	ted	15. Decedent's Edi	ucation 16a	. Decedent's Usual Occu	pation	161	wh:	
215	hin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	fe completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of wo	rking		
	should be filed withir and Mental Hygiene. marked other than matic evant, It e Me	P	1.0	none			unk		unk
pu	be filed tal Hygid d other evant, III	3e (17. Father's Name (First, Middle, Last)			18. Mother's Na	ne (First, Middle, Mai	den Sumame)	
la	ould be Mental harkad o	To Be	William Henry Kru	ıger		Helen Ha	anson		
Maryland	2 sho and lis me		19a. Informant's Name/Relationship (T)	/pe, Print) 19b	. Mailing Address (Street			ity or Town, State, Zij	Code)
	of Health itam 27 i		Randy Kruger/neph	ew 1	7736 Cliffbo	ourne Lan	e Derwood.	MD 20855	
Baltimore,	of He of He fitan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of	t Disposition (Name of ry, crematory or other pla			c. Location - City or T	own, State
Ĕ	Pages nent of l ant: If its ary or o		`4 □Donation 5 🖾 Other (Specify)						
alt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral S rvice Licens	ee //	22. Name and Addre				
m	89898		Ronald S.	wade Director	State Anat Baltimore	tomy Boar MD 2120	d 655 W. B	altimore :	Street
	Physician /Medical Examiner		23a. Part1. Enter the disease, of comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do ne cause on each line. a. SOSIS Due to (orlas a consequence	of):	•	or respiratory arrest,		Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the buriat-transit	icai Examiner	Sequentially list conditions, if any, search 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)		CON			
87	phys the			d					
O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deliver	ery Day Year
P.O.	that t	P.	Part II. Other significant conditions col	ntributing to death but not resulting in	the underlying cause an	(on in Part I	23e Did tohaar	o use contribute to the	an anuse of death?
Records,	quires tha in signed l uld be det	Completed by		is osteomyelis			1 Tes		,
00	s been s s been s s should	ojet					24a. Was an	24b Were auto	nsv findings available
R	The lay ate has page 2:	Ho					autopsy performed	? death?	psy findings available appletion of cause of
Vital	ilcian: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Dea	th (Check only one)	No 1 Yes	2 L NO
f <	si di	ToB	examiner?	lospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Oth		ome 5 Residence	6 □Other (Specifi	41
J of	ding Ph h. After thi funeral		27. Manner of Death		ime of 28c. Injur	y at	28d. Describe how in		,
0	ath. ath. pr: Af	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 70a)		Yes 2□No			
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune fune.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Location (Street City or Town, St	and Number or Rura	l Route Number,
	pital purs a surs a surs a silled i		29a. Certifier 1/V Certifying Phys	inian Tall					
	24 ho 24 ho Eun etely	Medical	(Check only one)	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the tir d/or investigation, in my o	ne, date and place pinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
	orthin orthin ompl	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. I	Date signed (Month.	Dav. Year)
	r s ⊢ ő		Geetha Paya u	10	187	7541	M	ay 2 . 2	006
			30. Name and address of person who co	moleted cause of death (Item 23a) (Type Print)	<i>→</i> [1		7	
			GEGTHARAJA	MD 4367 Holl	lus Ferry B	ed, Ba	Utimore,	MD-81	227
20	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 2005	mpleted cause of death (Item 23a) (M.) 4367 Holl	Selen .				

		i	For State Registrar	State of Maryla		artment of H <i>rtificate of l</i>			iene 006	14456	
	Physici /Medic	-	Decedent's Name (First, Middle, Last)	Paul Euge	ne Keife	er		2. Date of Dea Month	Month Day Year May 4, 2006		
)	Examir		4a. Fecility Name (If not institution, give s	treet and number) 25 Diamondback	Dr.	4b. City, Town, or	Location of Death	olumbia	4c. County of Dea	_{th} Howard	
***	Funeral Director		5. Social Security Number 6. Sex 216-22-5126 Usuel Residence of Decedent	7. Age (In y	rs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day December		thplace (State or Foreign cuntry) Maryland	
Maryland	a-f show	tor	10a. State 10b. County	oward 10c.	City, Town or Lo		Columbia		10d. Inside City Limits 1 ☐ Yes 2 XNo		
th with the	23a or 28	al Director	10e. Street and Number 9425 Diamondback Dr.			10f. Zip Code	21045	1	0g. Citizen of What Co	ountry? J.S.A.	
ISO rs after dea	i, or itams	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1's yes 2 □ No If Yes, Give Year or Dates:	1055	Was Decedent of H If Yes, specify Guba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Si in, Mexican, Puerto Specify:	Decify Yes or No- Dican, etc.)	14. Race - Ame Black, White Specify:		
3500-6121;	LING Z I Z I 3-0030 be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, I'm Medical Examinat must be notified at		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece	dent's Usual Occupi skind of work done of DO NOT use retired Ban	during most of wor	king	16b. Kind of Business State	Industry of Maryland	
Maryland 2	nd Mental Hygin marked other matic event, I	To Be Completed	17. Father's Name (First, Middle, Last) George Henr	y Herbert Keifer			18. Mother's Nam		Maiden Sumame) Ruth Keiling		
	ls m		19a. Informant's Name/Relationship (Ty) Mrs. Dorothy Keifer	Wife		9425 Diamor		olumbia, Ma			
Imore	ant: If		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	osition (Name of matory or other place set Memorial	Park 0	Date 5/10/2006	20c. Location - City or	Town, State	
	Depar Impor any ir		21. Signatur of Funeral Service Licent	land muss	35	3871	Funeral Hon Old Columbi	a Pike Ellico	tt City, MD 210	43 Approximate	
	hysician /Medical xaminer		23 Part1. Enter the disease or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		pulmon sequence of):	ary Arre	est			Interval Between Onset and Death 1 d a y	
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De death certific	y the attending phiched for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3 (Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
rds, P	been signed by the a should be detached to	ed by Pł	Part II. Other significant conditions cor Narcolepsy	atributing to death but not	resulting in the t	underlying cause give	en in Part I.	23e. Did to	pacco use contribute to es 2 ☑ No 3 ☐ P	o the cause of death? robably 4 □Unknown	
		Complet	Hypertensio	n				24a. Was a autops perform	prior to death?	utopsy findings available completion of cause of	
DIVISION OF VITAL RECORDS,	After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Many of Death 1 Natural 5 Pending investigation	lospitat: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	of 28c. Injun Worl	er: 4 Nursing H		e) ance 6 Other (Spe ow injury occurred	ncify)	
DIVISI	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st ecify)	reet, factory, office	10.	28f. Location (Si City or Town	reet and Number or R n, State)	ural Route Number,	
H ed	within 24 hours To the Funeral completely filted	edical		sician: To the best of my ner: On the basis of exam and manner stated.		nvestigation, in my o	pinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)	
Ę	within 2 To the	Σ	29b. Signature and title of certifier A S Lee L	losti-		29c. Licens	a number		9d. Date signed (Moni	in, Day, Year)	
	D		30. Name and address of person who cover Vellanki, N. B. MD 885	0 Columbia 100 l	Pkwy., Suite	, Print) e 308 Columi	oia, MD 2104	.5			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) -	32. Registrar's S	ignature						

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:05 AM Doris Lynne Lombardi 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Square 6. sol Baltimore HUSpita Franklin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Feb. 7,1939 Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 X X E 220-34-5758 Director 67 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1328 Burke Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XXMarried ō 1 Yes XXNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 2 should be filed within 72 hours and Mental Hygiene.

Is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary State Of Maryland 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Ziegler Doris Shortt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If Item 27 Is sny injury or other trau Anthony J. Lombardi, Jr. (Husbard) 1328 Burke Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ② ☐ Cremation 3 ☐ Removal from State Bayview Crematory, Inc.May 8,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Semilars of Fur crafts a wee Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Sher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. fmmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo į Month 4 Pregnant at time of death 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospitaf: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending within 2. To the

om Bardi

State Registrar

DHMH 17 Rev 1/2001

completely

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medicai

Fereidouni 9000 Franklin Qual Drive

and manner stated.

tereidouni Name and address of person who completed cause of death (Item 23a) (Type, Print)

Res 00000

			1 - For State Registrer	State of Ma	aryland		rtment of tificate o		d Menta	al Hygien	2000	14458
	Physici /Medi		Decedent's Name (First, Middle, Last Helen Legrand						Ap	te of Death	8 2000	3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give Mary and 67 5. Social Security Number 6. Se	eneral x 7. Age	HOS (In yrs.ha	Distal ast birthday)	Bal7		() >	Ly Birth	2. County of Dea	thplace (State or Foreign
	Director		240-18-9443 Usual Residence of Decedent	☐M 2(ĂF	81	Yrs.	Months Day	rs Hours M		onth, Day, Year) Co	unk
	death with the Maryland ims 23a or 28a-f ehow I mart be notillised at	ector	10a. State 10b. County MD 10e. Street and Number		•	Town or Loc	2			100	**	10d. Inside City Limits 11⊠ Yes 2 ☐ No
72. 9		Completed by Funeral Director	3809 Belle Avenue 11. Marital Status unk 1 \(\text{Never Married} \) 2 \(\text{Married} \)	12. Was Decedent E Armed Forces? 1Yes 2N If Yes, Give		nk If	10f. Zip Code 2121. as Decedent of Yes, specify Co	5 f Hispanic Origin? uban, Mexican, Pu	(Specify Ye	USA es or No-	14. Race - Ame Black, Whit	erican Indian,
1215-0036	within 72 hours after ene. than "naturel", or ite	mpleted by	3 Widowed 4 Divorced 15. Decedent's Edd. (Specify only highest grad Elementary/Secondary (0-12) unk	Year or Dates: Ication le completed) College (1-4or 5-	+)	16a. Decede (Give k	ent's Usual Occ	supation ne during most of v ired)	working	16b. F	Kind of Business/	ack Industry
en 1	should be filed and Mental Hygical Is marked other and marked other and market other and market event, It	To Be Co	17. Father's Name (First, Middle, Last)	nk			unk		lame (First,	Middle, Maidei		unk
Baltimore, Mary	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item once.		19a. Informant's Name/Relationship (7) Maryland General 20a. Method of Disposition 1□Burial 2□Cremation 3□F 4□Donation 5 營Other (Specify)	Hospital	20b. Pl:	827 I		et and Number or		. MD 21		
Balti	permit. I Departm importar eny inju		21. Signature of Funeral Service Licens Ronald S	Wade, Jir	cter	22. S B	Name and Add tate Ar altimor	ress of Facility natomy Bo re, MD 21	ard 6 201	55 W. B	altimore	e Street
8760,	Physician and /Medical Examiner prize and the pricial-transit	dicai Examiner	23a. Part1. Enter the disease, or of one shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line a. <u>Endlo</u>	e. Fox s conseque	ence of):	ShuC	ying, such as card	iac or respii	ratory arrest,		Approximate Interval Between Onset and Death
Box 6	Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 Fetal	death 3□E	ectopic pregnar Other (specify)	ncy			23d. Date of del	ivery Day Year
rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions col	ntributing to death bu	t not resul	ting in the und	lerlying cause (given in Part I.	23	le. Did tobacco	_	the cause of death?
Division of Vital Records, P.O.	: The law requ cate has been , page 2 shoul	Completed							-	a. Was an autopsy performed? Yes 2	prior to death?	itopsy findings available completion of cause of
Vita	ician certifi ector	Be	25. Was case referred to medical examiner?	lospital:			10	26. Place of D	eath Chec	k only one		
ot	Phys this aldiu	2	1 Yes 2 No 27. Manper of Death	1 Inpatien		R/Outpatient	3L DOA				6 ☐Other (Spec	afy)
rision	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.		28b. Time of Injury		☐Yes 2☐No		escribe how inju		iral Route Number.
DİV	ospital or hours after ineral Dire		29a. Certifier 1 Certifying Phys	sician: To the best of	f mv know	riedge, death	occurred at the	time date and pla	City	y or Town, State	and manner as	stated
	To the Hi within 24 To the Fu completel	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examination of the control of the co	on and/or inve		nse number	5	29d. Da	te signed (Monti	n. Day, Year)
	Sta	te	30. Name and address of person who so MOMAS 31. Date filed (Month, Day, Year)	propleted cause of de ROOA C	m	1019	gint) //	Jaryk	ind	Ger	28/04 repal	Gospity)
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Registrar

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RUTH McCANN

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	Exam	niner	4a. Facifity Name (If not institution, Stella Maris Du.		,		4b. City, To		ocation of Deat			tc. County of			
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	To the To the To the complet	Me	29b. Signature and title of certifier				29c. Lie	cense n	umber		29d. D	ate signed (M	lonth, Da	y, Year)	_
				0				172	5721			5/8/1	16		
	χ_{ℓ}		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type, P	Print)		- 1			10/	-		
			DR. TARIQ MAHMO		DULANE			T	EMONIUM.	MD 21	093				
	S Regis	tate trar	31. Date filed (Month, Day, Year)		gistrar's Signat	ture									

ROSELLE MCINTOSH

	-	_ State	tate of Maryland						ne O O O	·	
		Registrar		Cer	Tilicate o	Deam	2 02	Reg. I te of Death	No.	3. Time of Death	
hysicia /Medica	in al	Decedent's Name (First, Middle, Last) Jyothi	Day 20	56 5:33 A							
Examine	er	4a. Facility Name (If not institution, give stre Doctor's Community	Hospital			nham		P	4c. County of Death Prince George's		
ineral ` rector		5. Social Security Number 215-35-0377 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day			te of Birth onth, Day, Yes	ar)	Birthplace (State or Foreig Country) India	
f show		10a. Slate 10b. County Maryland Prince Geor	_	, Town or Lo	cation Lanh	am				10d. Inside City Limit 1 ☐ Yes 2XN	
a or 28a	Director	10e. Street and Number 6203 Erland Way			10f. Zip Cod	20706	5	10g.	Citizen of Wh		
rai, or items 23a or 28a-f show Evaluation into the collision at	/ Funerai	11. Marital Status 1 Never Married Married 12.	Was Decedent Ever in U. Armed Forces? 1 Des 2 No If Yes, Give		Was Decedent of Yes, specify C		gin? (Specify Yin, Puerto Rican,	es or No- etc.)	Black,	American Indian, White, etc. Asian Indian	
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7 is marked other than " traumatic event, the Met	To Be	17. Father's Name (First, Middle, Last) Lakshmanna	Jandhyala			Anr	napurna		Tadep		
traum		19a. Informant's Name/Relationship (Type, Sharma B. Murukutla	0.00				er or Rural Rout Lanham		ty or Town, St)706	ate, Zip Code)	
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Importer any Injur once.		21. Signature of Funeral Service Cicensee	M003	22 R	Name and Adapp Fun	dress of Facili eral ar		ation S	Service		
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signed by the attending physicien and d be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of dego Unknown	Ideath 3	□Ectopic pregna □ Other (specify				23d. Date Monti		
signed by d be detac	by	Part II. Other significant conditions contri	buting to death but not res	ulling in the u	inderlying cause	given in Part	I. 2			ute to the cause of death?	
e has been si age 2 should b	Completed							4a. Was an autopsy performed ☐ Yes 2	d? pri	ere autopsy findings availa or to completion of cause (ath?] Yes 2 🔀 No	
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To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	cation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h	28b. Time o	М	njury at Work? 1 Yes 2]No	escribe how i		or Rural Route Number,	
To the Funeral Director: completely filled in by the	Certif	4 Homicide determined	building, etc. (Specif	(y) 			C	ity or Town, S	State)		
ne Fune Jetely fi	edicai		ian: To the best of my knor: On the basis of examina and manner stated.								
To the	Me	29b. Signature and title of certifier Patrone MD. 29c. License number 29d. Date signed (Monte) 5-6.									
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06-02921

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Efrain Martinez		State of Maryland / Department of Health and Mental H 1-For State Certificate of Death		7. 2. 2	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	eg. No.	3. Time of Death
Medical Exami	:111/	EFRAIN MARTINEZ MALAVE	Month April 30, 2		1917 hrs
(4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore	1	4c. County of Dear	th
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Bir	th(MM/DD/YYYY) 9. B	rthplace (State or
Director		583-72-94/4 1XM 2 F 49 Yrs. Months Days Hours Min	٠.	10 1957 Fore	
	ł	Usual Residence of Decedent	I mick	10, 1931	
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
yland a-f sho	혅	Maryland Baltimore 10e. Street and Number 10f. Zip Code	171	0g. Citizen of What Co	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Member Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fshow a traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 2912 Pulaski Highway 21224	l "	U.S.	
with t ms 23a be not	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			ncan Indian, Black,
r death w or items	Fune	1 Never Married 2 Married 3 Widowed 4 Divorced of Yes Pates: Armed Forces? 1 Yes 2 No 1 Yes 2 No Specify Cuban, Mexican, Puerto		White, etc.	eta Ricai
rs afte	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Tuck 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business	
72 hou n "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret			el's Tires
5-0036 led within 7 Hygiene.	dmo	11 Mechanic			7/10
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212 buld be I Ment s mark	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Num	nber, City or Town, Stat	e, Zip Code)
MD ad 2 shalth and m 27 is		An		Elkridge,	T 0: :
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after the filed Monal Hygies and the filed Filed Winter after the filed Transfed other than "natural", in other traumatic event, the Medical Examiner.	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location City of	r Iown, State
드 ~ 일 등 등		4 Donation 5 Other Specify: Green out Cem. MA	19,2006	DAITIM	ore, MD
Balti permit. Departu Imports	ļ	More Lanning Joseph N. Zan	LING 5	Jr. Fund	UNDIZZA
Physician		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Cart Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on such line.	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical √ Examiner		Immediate Cause (Final diseas a. ASTIVALA due CO Trangling			Death
1		or condition resulting in death) Due to (or as a consequence of):			
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sici	ledical	IF FEMALE: AMENDED item#23a,27,28a-f,perME,G855,5/23/06 23c. If yes, outcome of pregnancy) 11	23d. Date of delive	21
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	ian/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	ancy	Month	Day Year
Box (e death ce the attence of for use	ပေ၊	1 Yes 2 No 9 Unknown Pregnant at time of 5 Other (Specify)			
P.O. Bo; so that the death gned by the att	, Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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n of Vi ding Physi After this funeral dir	<u>د</u>	1 ✓ Yes 2 No Impatient 2 ✓ Ervoupatient 3 DOA 4 Notice 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		how injury occurred	
ion tendin eath.	atior	1 Natural 5 Pending Accident Investigation 4/30/2006 Find 6:41 PM 1 Yes 2XX No	subject h	anged self	
Division of Vital Records, rate for a Attending Physician: The law require and redeed the The The The This certificate has been siled in by the funeral director, page 2 should be	Certification:	3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or R State) 2912 Pulas 2, MD	ural Route Number, City ki Highway
Divis To the Hospital or A within 24 hours after To the Funeral Dire		29a, Certifier			
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To To	Me	and manner stated. 29b_ Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
· Notard		Caliel O.C.M.E.		May 2, 2006	
John	1	30. Name and address of person who completed of use of Cath (Item 23a) Zabjullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
	ate		-01		
Regis		MANA O 200CL EL MARCHE			

			1 - For State Registrar	State of Maryla			nt of Healt te of Dea		Re	g. No. []	06	1 6	3_
	Physici		Decedent's Name (First, Middle, Las	Margaret	C. Me	lvin			2. Date of Death Month 5	Day	Year 2 006	3. Time of Death 8:00 a	
ja.	/Medic Examir		4a. Fecility Name (If not institution, give		C. He	,	Town, or Locat	tion of Death	<u> </u>		nty of Death	.L	
			2505 W. Lanvale	Street			Balto			N	/A		
· (%)	Funeral Director		5. Social Security Number 6. Security Number 212-03-3279 Usual Residence of Decedent	ax ☐ M 2【XF 7. Age (In y) 103	rs. last birthday) Yrs.	If Unde Months	r 1 Year If Ur Days Hou		8. Date of Birth (Month, Day, 2-28-1	Year)	-	place (State or Fore ntry) Md	əign
	yland yland		10a. State 10b. County	10c.	City, Town or Lo	ocation						0d. Inside City Lim	nits
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	or 28	Director	10e. Street and Number			10f. Zij	Code		10	g. Citizen	of What Cou	ntry?	
	ath w	ra	2505 W. Lanvale				21216			US			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28a-f ehow way injury or other treumatic event, the Madical Eram, as must be notified at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	-	Was Dece If Yes, spe	dent of Hispanio city Cuban, Mex 2 X No Spe		cify Yes or No- Rican, etc.)	Spe	Race - Americal Black, White, scify: Black	etc.	
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Ž	should Me Me Merk	ပို	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Addres:			Route Number,	City or Tov	vn, State, Zig	Code)	
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Baltimore, Maryland 21215-0036	Pages 1 a nent of Hea ant: if item ury or othe		20a. Method of Disposition XXBurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Dispo cemetery, crei Md Nat	osition (Na matory or d	me of other place)			loc. Locatio Laure	n - City or To	own, State	- '
Balt	Departi Departi Importi eny inj		21. Signa uri of Funeral Service Licens	Kek		43	300 Waba	ash Ave	ch F/H nue Bal	to, M	D 2121	5	
	Physician /Medical		23a. Part . Enter the disease, or comp shock, or hearh dilure. List only of Immediate Cause (Final disease or condition resulting in death)	Left Bre	ast (ter the mod	de of dying, such	n as cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death	_
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٧ ق	cate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	c. Due to (or as a cons	equence of):	-to	thr	ive				6 month	5
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.O. Box	The law requires that the death certific lie has been signed by the attending p rage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic p □ Other (sp					Date of delive Month	ory Day Year	
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		Completed							24a. Was an autopsy perform 1 Yes 2	ed?_	b. Were auto prior to co death? 1 \(\text{Yes}	psy findings availal npletion of cause o 2 No	ble ot
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on	ding th. After	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes 2		04. 00001100 1101	· injury coo			
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	reet, factor			8f. Location (Str. City or Town,		m <i>ber</i> or Rura	l Route Number,	
	ne Hospital n 24 hours ne Funerei Metely filled	edical (29a. Certifier (Check only one) 2 Medical Example 1 Medical Example 1	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred vestigation	at the time, date n, in my opinion,	e and place, a death occurre	nd due to the car d at the time, da	use(s) and te and place	manner as s e, and due to	ated. the cause(s)	
	To the Hi within 24 To the Fi complete	Ň	29b. Signature and title of certifier	2 1 15	(29	c. License numb	oer	29	d. Date sigi	ned (Month,	Day, Year)	
			> Suntan	1 PATRI	JAN		D002	7014	-	5	13/1	6	
	10		30. Name and address of person who c	ompleted cause of death (It	em 23a) (Type,	Print)	huato	n Pol	vd. Al	Ut.	dur	21230)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	P	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 11 per inf. 8855 5-23-06 vt. State of Maryland / Department of Health and Mental Hygiene RegiNo.UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 2006 Mae West McDonald 4:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Catonsville Balto If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2∰F Yrs Director 69 241-52-6140 4-15-1937 N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be notified at 1X Yes 2 No Md N/ABalto Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3237 Normount Avenue 21216 USA e filed within 72 hours after death vit Hygiene.
other then "natural", or Iteme 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Johns Hopkins Hospital Elementary/Secondary (0-12) College (1-4or 5+) 3 years 12th grade Registed Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 Is marked oth Leroy Williams, Sr Connie Stokes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Garris - Grandson 720 Tidewater Circle Apt 27 A Macon, Ga 31211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Druid Ridge Cemetery 5-6-2006 Balto, Md 21. Anature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE SLEED **Physician** Twi YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. | 9 Unknown 9 Unknown signed I d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown INFECTION Completed HYPEN TENSOON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification: To After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the ...
Within 24 hours after ...
To the Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 00 D0061765 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUMINOU WO 2350 WILKENS AVE #307 BACTIMENE MUD 21225 32. Registrar's Signature State 9 2006

Registrar

Salar.

			1 - For State Registrar	State of	Marylar	nd / Depa		Health and M	Mental Hygi	_	14465
	65.4	-ej	1. Decedent's Name (First, Middle, I	_ast)					2. Date of Death		3. Time of Death
	Physic /Medi		Larry	Γ			Mil	es	Month 0.5	Day Yeer 0.2 2.006	10.20.M
	Exami		4a. Facility Name (If not institution, g Gilchrist Nur				4b. City, Town,	or Location of Death		4c. County of Dea Baltimo	th ±0.00p
Jaac	Funeral Director	112	217-64-5327	. Sex 7. 1 X M 2 □ F	Age (In yrs.	las <i>t birthday)</i> Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Day,	rear) C	thplace (State or Foreign ountry)
7	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
>	daryl f sho	ö									1 XYes 2 No
3	n the Marylan r 28a-f show	Funeral Director	MD NA 10e. Street and Number		Ва	altimo	10f. Zip Code		10	Citizen of Miles	**
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ر د دو	after dea or itama	F	1 ☐ Never Married 2X Married	Armed Forc	es?	10.	Yes, specify Cui	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Black, Whi	
30/03	al', o	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Date			Yes 2 No	Specify:		Specify: E	Black
15-0036	within 72 hours after death with the Maryland ene. Than "natural" or lrama 28a or 28a-f show Medical Examinar must be notified at	ted	15. Decedent's (Specify only highest of			16a. Deced	lent's Usual Occu	pation	11	6b. Kind of Business	/Industry
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- 6	C = W =		Dawn P. Miles: 20a. Method of Disposition	-Wife	205 8	3208	Batav sition (Name of	ia Ave,	Baltimo	re, Md	21214
Miles,			1 XBurial 2 ☐ Cremation 3		ate 200. F	emetery, cren	natory or other pla	ace)		c. Location - City or	Town, State
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Z la	Department Department of the police of the p		21. Signature of Funeral Service Lic	ensee)		Ma	rch F/	ess of Facility H West			
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		8	23a. Part1. Enter the disease, or co shock, or heart failure. List on	y one cause on eac	Nine.	n. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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189	tificate ng phys as the			o.							
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ğ	death s atte	cla	in the past 12 months?		n 2 ☐ Fetal tat time of de		Ectopic pregnand Other (specify) _	Э		Month	Day Year
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ž,	quire in sig uld b								1. Yes	2 □ No 3 □ Pr	obably 4 Unknown
8	law rei es bee 2 sho	ojet							24a. Was an	24b Were au	itopsy findings available
æ	The lay te hes age 2	Completed							autopsy performe	d? prior to death?	completion of cause of
ta	an: tiffica tor, p	BeC	25. Was case referred to medical					26 Place of Death	1 ☐ Yes 2) h Check only one	7 No 1 ☐ Yes	2 🗆 No
2	ysici is cer direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ fnp	atient 2 .	ER/Outpatient	3□ DOA Ct			ce 6 Other (Spe	the Harass
Ö	ig Ph ter th neral		27. Manner of Death	28a. Date of f (Month,		28b. Time of Injury	28c, Inju		28d. Describe how		IN TIOSFICE
.0	uttendir death. ctor: Af y the fur	atic	1 Natural 5 Pending 2 Accident investigate	on	bay rour,	прату		Yes 2 No			
Division of Vital Records,	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	1 28e. Place of	Injury - At ho	me, farm, stre	et, factory, office		28f. Location (Stree City or Town,	et and Number or Ru	ıral Route Number,
Q	ital or irs afte ral Dire	Cer			(0,000)	,			University of Town,	Siale)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier Certifying P (Check only one)	hysician: To the be iminer: On the basis and manner	s ot examinat	wledge, death ion and/or inv	occurred at the transition, in my	me, date and place, opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licens			Date signed (Monti	
	,		Municipal	~>				8303	m	' / -	.00 <u>c</u>
			30. Name and address of person who		of death (Item	23a) (Type, P		N. CHAR	LES STRE	ET	
-			HAREN CHANUES.				Tow	SON M	D ZIZO	4	
	Sta Registr	00.00	31. Date filed (Month, Day, Year) MAY 0 9	23	strar's Signat	ure	cast D				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 **Physician** LOMUND MOORE W 6-20 AM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CHRIST ENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 2/16 9 Birthplace (State or Foreign Days Hours 1 4M 2 F Months 92 214-05-3776 Director Yrs. FENNSY IVANIA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at BALTIMORE Director MD KALTIMORE 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2920 21214 AVE Completed by Funeral WOOD USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: "natural" WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 6b. Kind of Business/Industry FREESTATE and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES EQUIPMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ORA SEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra MOORE 2920 FLEETWOOD AUE. BACTIMERE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Location - City or Town, State MAY 1 Durial 2 Cremation 3 Removal from State TARKWOOD ARKVILLE, MD 4 □ Donation 5 □ Other (Specify) CEMETERY 2006 21. Signature of Juneral Service Doensee 22. Name and Address of Facility 8800 HARFORD CO. PARKUILLE, MD 21234 CHAPEC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate **Physician** disease or condition resulting in death) Cancer Kals /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation

Box 68760, P.O. 1 Division of Vital Records, : After this certifical funeral director, r or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the Hospital

Baltimore, Maryland 21215-0036

2 Accident 3 Suicide

29a. Certifier

31. Date filed (Month, Day, Year)

Medical

6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

D0061199

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

May, 6, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N, CHARLES TREET Black lowson, MD

State Registrar

9 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death DDPM CATHERINE LOUISE MARTIN May 7006 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Runnie Mnnd If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, MAY 15, 5. Social Security Number 6. 96x 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) W • VA Months 1□M 20 F 234-01-7651 95 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7885 GORDON COURT # 597 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3√2 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES CUSTER PEARL GREGORY

630 SANDY HILL RD.

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

CEDAR HILL CEMETERY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SEVERN, MD 21144

MAY 8, 2006 BROOKLYN PARK, MD

1 SECOND AVE. SW

20c. Location - City or Town, State

Completed by Funeral Be

Director

Physician

/Medical

Examiner

Funeral

Director

For State Registrar

10a. State

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Oprier (Specify)

21. Signatu s of Fineral Service Lice see

20a. Method of Disposition

MRS. BETTY GALLOWAY/ DAUGHTER

1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State

MAY 0 9 2006

31. Date filed (Month, Day, Year)

MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-f show any highry or other traumatic event, if a Medical Exact as must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, 6 sate has been sign page 2 should be certificate within 24 hours after death To the Funerei Director: completely filled in by the

1100	rio i	ALL SINGER	ION FUNERAL I	HOME GEEN DOKNIE,	MD 21001
23a. Part1. Enfer/the disease, or c shock, or heart failure. List o	omplications that caused the denty one cause on each line.	ath. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Conal	12-ve	wan 1	taslive	Oriset and Death
resulting in death)	Due to (or as a conse	equence of):		0	
	Corpor	C ()	~ they	disins	
Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		J		
cause. Enter Underlying Cause (Disease or injury	11 12	en this	707		
that initiated events resulting in death) Last	c. Due to (or a) or e	equence of);	•		
		. ,			
	d				
IF FEMALE:	23c. If yes, outcome of preg	22201			
23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fe	tal death 3 Ectopic		23d. Date	•
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Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
				1 □ Yes 2 No 3	☐ Probably 4 ☐Unknow
				24a, Was an 24b, We	ere autopsy findings available
				autopsy pri	or to completion of cause of ath?
		_		1 Yes 2 No 1	Yes 2 No
25. Was case referred to medical examiner?	Monitol			ath (Check only one)	
1 ☐ Yes 25 No	N	☐ ER/Outpatient 3☐ □	OOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other	(Specify)
27. Manner of Death 1 S Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred	f
2 ☐ Accident Investiga	ition	М	1 ☐ Yes 2 ☐ No		
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		home, farm, street, facto	ry, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
1 Difficial	building, etc. (Spec	ary)		City of Town, State)	
29a. Certifier	Physician: To the best of my kr	nowledge, death occurre	d at the time, date and place	e, and due to the cause(s) and mann	ner as stated.
(Check only 2 Medical Ex	xaminer: On the basis of examination and manner stated.	lation and/or investigation	n, in my opinion, death occ	urred at the time, date and place, an	d due to the cause(s)
29b. Signature and title of certified		2:	9c. License number	29d. Date signed (Month, Day, Year)
	mi	7	March	ntlail	2121/
0	1.10	ly ly	48000	05/04/	2000
30. Name and address of person w	no empleted cause of death (Ite	om 23a) (Type, Print)	11/1	Galan Ru	and my
IZ (/TO I KU)	- I V	VI INOT.	- 10 tol loc	/ 4) / 1 / 3 4 1	וורמיי
	11 1 3	1 8	Y	-/ / /	

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day George Henry Magaha, Jr. 5-4-2006 11:00 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□F Director 215-34-9369 69 11-10-1936 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show show 10d. Inside City Limits Director 1 ☐ Yes 2 X No MDAnne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? if Itam 27 is marked other than "natural", or Itams 23a or or other traumatic event, the Medical Examinar must be a 7668 Old Telegraph Road 21144 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Ma Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Henry Magaha, Sr. Myra Elbourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Itam 27 is eny injury or other trau Mrs. Rosalie Maraha / wife 7668 Old Telegraph Road; Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem 5-8-2006 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA Moissyl Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freen failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 □No P.0. 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2**X** No 4 ☐ Nursing Home 5 ☐ Residence 6 ⚠ Other (Specify) this HOSPICE ieral Director: After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 0 within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 9 2006 Registrar

2006

GEORGE MAGAHA

Amend item#8, perffl. 2833.5/16/06 The Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JAMES AaRON McGEE pril 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 345 8711 and If Under 24 Hrs. 8 5. Social Security Number If Under 1 Year Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months MARYLAND Days T971980 Director 220-94-4425 25 Yrs. Usual Residence of Decedent 10a. State 10b. County ral, or iteme 23a or 28e-f show Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGES COLLEGE PARK 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8711 34TH AVE. 20740 USA permit. Pages 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene.

Importent: If item 27 is marked other than "natural", or lieme 23a any injury or other traumatic event, tra Medical Examinar monta. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Tes 27 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) OFFICE SUPPLY Elementary/Secondary (0-12) College (1-4or 5+) 12YRS MANAGER INVENTORY 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) JAMES HENRY MCGEE JR. CAROL ANN GRACE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3734 E "I" ST. TACOMA, WASHINGTON 98404. CAROL ANN GRACE (MOTHER) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CEMETERY HOME 05/10/2006 TACOMA, WA. 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses JENKINS & SONS CO. RK RD. MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (vi as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 es 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred Huge After 1 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 INO nours after death nerel Director: A filled in by the f 2 Accident investigation 28,206 1416 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide College. Hospital within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as flated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Jose 31. Date filed (Month, Day, Year) State MAY 09 2006 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 Amend #8&19a PEr FH G855 5/09/06 TH Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last, Day Year Physician 6 2006 5 Mitchel 2 lorence /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Baltimore Green Nusuna Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1□M 2XF 94 Yrs. MD213.09.515 11/21/1911 Director Usuel Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 X Yes 2 □ No Baltimore MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 5111 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Ever in U,S Armed Forces? 11 Marital Status Black, White, etc. permit. Pegas 1 and 2 should be filed within 72 hours effer to Depertmant of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or Nes 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 Mo Specify: Specify: Saltimore, Maryland 21215-0020 ٥ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturno Fabric Tester Mygrade 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Florence Flemino Lane NNOL 19b. Mailing Address (Street and Number or Rural Route Number, City or Swn) 19a. Informant's Name/Reletionship (Type, Print) Dele Delores M. Fowlkes/daughte 5111 Herring Run Drive Balto. MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/08/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) dress of facility Funeral Services 21. Signature of Funeral Service Licensee Baltimore MD 21212 York Road un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or As a consequence of) Examine ettending physician end for usa as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No cartificate has been signed lirector, page 2 should be dat 2 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2010 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to predical tor: Attar this cartific the funeral director, 26. Piece of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 1 Yes 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending 1. Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 24 hours efter death. 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier

State Registrar

within 24 ho
To the Fune
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29b. Signature and title of certifier

30. Name end addre

of person who

31. Dete filed (Month, Day, Year) 9 2006

Deck 32 Registrar's Signature

pleted cause of death (perio 23e) (Type, Print)

29d. Date signed (Month, Dey, Year)

2006

Mac

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death McFadden - Williams Month Year Emma 11:15AM 05 63 2006 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 29th Street NIA Baltimore 1 Year | If Under 24 Hrs. Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 219.40.8581 1 ☐ M 2 🔭 F SC 03/19/194 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltmore MD NIA 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 E. 29th Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maintenance Barre National 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony McFadden Queen Kenned 19a. Informant's N. e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katie McFadden New Zion SC 29111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cometan Baltimore MD 22 Name and Address Uncility Yaughn C. Green 4909 York Road 21. Signature of Funeral Service Licensee rene Funeral Services Dad Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Of Pancseas Due to (or as a consequence of): putersion yours Sequentially list conditions,

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O. Box	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of deliven	/ Day Year
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of Vital	Physicien: The iaw this certificate hes t ral director, pege 2 s	To Be C	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	26. Place of Death (C/te	The state of the s	pt NO
Division o	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Statural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatio 6 Could not b determined	escribe how injury occurred cation (Street and Number or Rural in ty or Town, State)	Route Number,	
	he Hospit n 24 hours he Funera pletely fille	Medicai	29a. Certifier 1 Cartifying Pt (Check only one) 1 Medical Example	nysician: To the best of my knowledge, death occurred at the time, date and place, and duninar: On the basis of examination and/or investigation, in my opinion, death occurred at the manner stated.	e to the cause(s) and manner as stat he time, date and place, and due to t	ed. he cause(s)
•	To t withi To t	Σ	29b. Signature and title of certifier	Law Bon, MD, FACP 29c. License number D 57088	29d. Date signed (Month, Di	
	67		30. Name and address of person who Thom Pom , 30	completed cause of death (Item 23a) (Type, Print) 51 St. Paul Plann, #701 Baltimon, M	D 21202	
7	Stat Registra		31. Date filed (Month, Day, Year) MAY 0 9 200	6 2. Registrar's Signature		

Physician

/Medical

Examiner

Director

Funeral

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if of Health and Mental Hygiene.
If item 27 is marked other than "naturel; or items 23a or 28a-f ehow or other treumatic event, the Medical Examination must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any injury or other treumatic event QDES.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

			1 - For State Registrer	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygie	2006 11.1.72
	Physic	ian	1. Decedent's Name (First, Middle, Last, Samuel Mr	raun		2. Date of Death Month	Day Year 3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	,	4b. City, Town, or Location of Dea		29 2006 0612AM 4c. County of Death
			Good Samuri	tan Hospital	Baitimo	ne	NIA
	Funeral Director		70 0000	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country)
	show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			10d. Inside City Limits
	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or items 23e or 28e-1 show event, the Medical Examinar rust be notified at	Funeral Director	10e. Street and Number		10t. Zip Code	10g.	1 Yes 2 □ No Citizen of What Country?
	s 23a o	raiD		till Avenue	21217		USA
ပ္	or Items	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ■Yes 2 □ No If Yes, Give	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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Mar	# 25 E g		19a. Informant's Name/Relationship (Ty	19b. Ma 18 / Sister 27	iling Address (Street and Number or F	iural Route Numbel, Cil Me Bat	
ore,	0 0	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dis	position (Name of rematory or other place)	Date 20c.	Location - City or Town, State
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			snock, or neert failure. List only or	^	nter the mode of dying, such as cardia	ic or respiratory arrest,	Approximate Interval Between Onset and Death
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leco	e taw requir has been si je 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital F		e Cor	25. Was case referred to fiedical		26 Place of Do	performed	
of Vi	Physician: this certific ral director,	To B	examiner? 1 Tyes 2 Tyo	lospital: 1 Inpatient 2 FR/Outpati	ent 3 DOA Other: 4 Nursing h	ath <i>Check ont one</i> Home 5□ Residence	6 ☐ Other (Specify)
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	Hospital 4 hours a Funaral I ely filled	Medical Ce	Check only 2 Medical Examin	sician: To the best of my knowledge, dea ner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. Index of place, and due to the cause(s)
0.10	To the within 2. To the complet	Mec	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	X		MM, MD		D5772	7 3	5/3/06
10	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		30. Name/and address of person who co	mpleted cause of death (Item 23a) (Type	Exerptored A	Jeman,	MD 21714
	Sta		31. Date filed (Month, Day, Year) MAY 0 9 200	32, Registrar's Signature	all	VVVVV	
	Registr	ai -	MAY 0 9 200	U JUNEAU SE SE			

			For State Registrar			/ Depa		t of H	ealth ar	nd Mental Hy	-	16. 36	14473
4	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, A 1 S Y 4a. Facility Name (If not institution,	NOLL					Location of I	2. Date of De Month	Dayl	Year	3. Time of Death
	Funeral Director		NORTHWEST HOSPI 5. Social Security Number 218-26-8744 Usual Residence of Decedent		ER 7. Age (In yrs. las 72	t birthday) Yrs.	-		If Under 24 Hours	Hrs. 8. Date of Bit Min. (Month, Da		9. Birthpla Country	E ce (State or Foreign V) NC
	the Maryland r 28e-f show	rector	10a. State 10b. County MD BALT 1 10e. Street and Number	MORE	10c. City,		STOWN	Code			10g. Citizen of WI		1. Inside City Limits 1. Inside City Limits 1. Inside City Limits 2. □ No
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene, itam 27 is marked other than "natural", or itama 23a or 28e-f show other traumatic avent, the Mudical Exercitating the notified at	by Funeral Director	3418 JANVALE RO	12. Was Dece Armed For d 1 [] Yes If Yes, Giv	2X No e					n? (Specify Yes or No Puerto Rican, etc.)	USA	- Americar , White, etc	n Indian, c.
Maryland 21215-0036	Jwithin 72 hours Jiene. r than "natural"	Completed b	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Da Education grade completed) College (1		(Give life.	dent's Usual kind of wor DO NOT us EAMST	k done d e retired)	uring most o	of working	16b. Kind of Bus		
aryland;	2 should be filed and Mental Hygid Is marked othar aumatic avent,	To Be C	17. Father's Name (First, Middle, L. JOHN WINIFORD 19a. Informant's Name/Relationshi						18. Mother's	s Name (First, Middle IE COTTON or Rural Route Numb			code)
Baltimore, M	permit. Pages 1 and 2 Department of Health Important: If itam 27 I any injury or other tra once.		DAVID NOLLEY/SC 20a. Method of Disposition 1 \(\text{Aburial } 2 \) Cremation 4 \(\text{Donation } 5 \) Other (Spontage of Funeral Service Li	□Removal from Socify)	State cem	ce of Dispo etery, crei CATH	8 JAN osition (Nammatory or other state) EDRAL 2. Name and	ne of her place CEM d Addres	MAY		20c. Location - C BALTIMOI MORTON &	RE, M	ARYLAND F.H., INC.
	Physician /Medical Examiner		23a. Parv. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. \\	ach line. RMINA or as a consequer	Do not ent	er the mode	R)17	N	erdiac or respiratory a		A	217 Approximate Interval Between Onset and Death
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Division of \	utanding Physideath.	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 4 Homicide determin	28a. Date of (Monti	of Injury 28	VOutpatier Bb. Time of Injury e, farm, str	M 28	Ic. Injury Work 1 🗆 Y	at Nursi	28f. Location (how injury occurred Street and Number	d	Route Number,
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)	To the within To the compl	Me	29b. Signature and title of certifier	6 m	ella m		C		1410		29d. Date signed (Month, Da	y, Year)
	Sta Registr	-	30. Name and address of person w 11. Date filed (Month, Day, Year) MAY 0 9 2	HC3017	of death (Item 20) AL CO	ENTE	Print) Je	RA	MONU NOER	13 TENAH	MO 2	133.	-
	riegisti	al	MHI U 3 Z	006	Eur A.	de	W.						

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** Month NOWOTARSKI orge NMN 2006 16:55 Max /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESAPEAKE MEDICALCENTER BEL-AIR UPPER HOSPITAL Harford If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 166-18-9192 85 Director 1920 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f ahow 10d. Inside City Limits 27 is marked other than "netural", or iteme 23a or 28a-f ahov traumatic avant, it e Medical Examinar must be notified at Directo Maryland | Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 Romney Road 21085 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☑ No Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Aircraft Manufacturer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Itam 27 is marked oth any injury or other traumatic avant <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam J. Nowotarski Mary (u/k) Lesko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl L. Nowotarski / Wife 2407 Romney Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Grdns 5-4-06 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit signed by the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No George Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, has certificate or Attending Physician: Be P this To the Funeral Director: After the completely filled in by the funeral Certification: death. within 24 hours after To the Funeral Dire

NOWOHarski

27. Manner of Death 1 Watural 2 Accident 3 🗌 Suicide 4 - Homicide

29a. Certifier

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

29b. Signature and title of certifier

Hospital: 1 4mpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 28b. Time of

3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29c. License number

. 16444

ca

1 ritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24a. Was an

1 Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY. S. NAIR M.D. 602-

State Registrar

Medical

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/200

To tha !

4 Dunknown

Year

Approximate Interval Between Onset and Death

M

1 Yes 2 No

3 ☐ Probably

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 - No

26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 15+2006

S. Atwood Road. Belan MD 21014

ORIGINAL

		1 - For State Registrar	State of M	-	partment of Fertificate of		Mental Hygier	2006	4475
Physic /Med		Decedent's Name (First, Middle, La	,	J. Nilsson			2. Date of Death Month May	7, 2006 Year	3. Time of Death 11:00 a.m.
Exami		4a. Facility Name (If not institution, give	e street and number) 10110 Carillo		4b. City, Town, o	r Location of Dea	Ellicott City	4c. County of Death H	oward
Funeral Director	_	5. Social Security Number 6. S 577-48-4274	60x I□M 201F 7. Ag	ge (In yrs. last birthda 70 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hr Hours Mir			place (State or Foreign ntry) California
Maryland a-f show	ctor	10a. State 10b. County	Howard	10c. City, Town or		Ellicott City			10d. Inside City Limits 1 ☐ Yes 2000
th with the 23s or 28	al Direc	10e. Street and Number 10110 Carilln Dr.			10f. Zip Code	21042		Citizen of What Cou	ntry? S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinant matcher cities at once.	by Funeral Director	11. Marital Status 1 Never Married 275 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 25 If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of H If Yes, specify Cuba	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours alf the and Mental Hygiene. 77 is marked other then "natural", or traumatic event, tra Macilcal Exemi traumatic event, tra Macilcal Exemi	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12		(Giv	edent's Usual Occup to kind of work done DO NOT use retired House	during most of wo	orking	Kind of Business/Ir Owr	ndustry n Home
yland /	To Be C	17. Father's Name (First, Middle, Last Ashtol	n Blair Jones	·		18. Mother's Na	ame (First, Middle, Maide Martha Ka	en <i>Sumame)</i> athleen Down	S
e, Mar 1 and 2 sho 1 eaith and 1 eaith and 1 m 27 is m ther traum		Mr. Knut I. Nilsson, 20a. Method of Disposition			10110 Carillr		Rural Route Number, City City, Maryland 2 Date 20c.	1042	
Baltimore, bermit. Pages 1 an Department of Heal mportant: If item 2 my injury or other ance.		Burial 2 Cremation 3 C 4 Donation 5 Other (Special 21. Signature) of Funeral Service Lice	(y)	Crest Li	ematory or other place awn Memorial 22. Name and Addre	Gardens	05/12/2006	Location - City or To	lle, Maryland
Dermi Depa Impo		23a. Part1. Enarthe disease, on com shock, or heart failure. List only	The Su	LIT	Slack 3871	Funeral Ho Old Columb	<u>oia Pike Ellicott C</u>	ity, MD 21043	Approximate
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a		bric C				Interval Between Onset and Death
. Box 68760, — death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
TO. BOX 68 If the death certifica by the attending pherached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of deliver	ery Day Year
S, I es tha gned be de	þ	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to the	he cause of death? pably 4 Unknown
- CG CT	Completed						24a. Was an autopsy performed?	prior to co death?	ppsy findings available mpletion of cause of
On Of ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		of 28c. Injury Work	er: 4 Nursing I	ath (Check only one) Home 5 Aesidence 28d. Describe how inj		(y)
i Si it e	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Flace of m	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Street a City or Town, Sta		al Route Number,
To the Hospital or within 24 hours aft To the Funeral Dis completely filled in	Aedical	one)	ysician: To the best niner: On the basis o and manner st	f examination and/or i	nvestigation, in my or	pinion, death occ	e, and due to the cause(urred at the time, date ar	nd place, and due to	o the cause(s)
To Too	Σ	29b. Signature and title of certifier	Eusley	MD	29c. License	5077	6 M	ate signed (Month,	2006
<i>\(\lambda</i>		30. Name and address of person who Site ve n 31. Date filed (Month, Day, Year)	VENS 1CM	MD 4 ar's Signature	SOI Dor	sey H.	ell Drive,	E11.20	++ City
Sta Regist		MAY A Q 2	W	A. J. Signaturo	casted				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year THOMAS O'CONNOR 2006 May 11:00/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
Oct. 20 106 Kenilworth Park Drive Apt. 3-D Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F Director 218-22-9049 78 Maryland Usual Residence of Decedent the Manyland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural; or itams 23a or 28a-f ahow traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Kenilworth Park Drive Apt. 3-D 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelin and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Examines-1 XYes 2 No If Yes, Give Year or Dates: 1946–48 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Telephone Co. Division Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Francis O'Connor Mary Ann Neubauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. O'Connor, Jr. (son) 243 Maple Wreath Court Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 5-10-06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Leone 1 Jenan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYRON MONATS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physicien and should be deteched for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending hours after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 50 SPEVEN 1650 ORGEANS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#15,16b,12,18,19b,20a 22, perFH 8855.5/10/06 TT and Mental Hygiene 0 6 16677 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician OROURKE MICHAEL RRANCE 4:30 A M 30 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rehabilitation Extended Come Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1₽M 2□ F Yrs. 368-42-2500 Director 63 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 is marked other than "natural; or items 23a or 28e-f show injury or other traumatic event, the Mudical Evantinar must be notified at 1X Yes 2 No MD Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 S. Ann St. #103 21231 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1959–63 1 Was Garrier 1972–75 14 Yes, Garrier 1972–75 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status tiled within 72 hours atter 1 ☐ Never Married 2 ☐ Marned Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 💆 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Shipping Industry unk Machinist unk 18. Mother's Name (First, Middle, Maiden Surname)
Alice M. Easton 17. Father's Name (First, Middle, Last)
Donald J. O'Rourke
J. Donald O'Rourke permi. Pages 1 and 2 should be tile Depertment of Health and Mental Hy Important: if Item 27 is marked othe any lipity or other traumatic event page. Be Alice Eastern b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 741 Laura Lane York, PA 17402 811 Sunset Prive Dallas Town, PA 17313 19a Informant's Name/Relationship (Type, Print) Brendan O'Rourke/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☑ Other (Specify) in state 5/9/2006 Baltimore, MD Metro Crematory, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremettin Society of MD, Inc. Ronald S. Wade Dire State Anatomy Joand 555 W. Baltimore Street Baltimore, MD 21201 200 Frederick Rd. Raltimore, MD Approximate 1228 Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** ung Cancer - Non Small cell /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day signed by the aid be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes № No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation death. 1 Yes 2 No atter death 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

completely ţ 0 0

Deborah Bullock 31. Date liled (Month, Day, Year) State Registrar MAY 0 9 2006

29b. Signature and title of certified

3900 Loch Raven Bowlevard, Baltimore MD 21218 MD 2. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

MD 072692

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Man	/land / Dep	artme		ealth and	Mental Hy	-	16	14478
Physicia /Medica Examine	al	1 Decedent's Name (First, Middle, Las Jamie Felix Ponte 4a. Facility Name (If not institution, give Arcola Health & I	street and number)	i an			Location of Deat	2. Date of Dea Month 05	02 2 4c. Coun	OO6	3. Time of Death 7:15p
Funeral Director		5. Social Security Number 6. Se	7. Age (II	yrs. last birthday 9 Yrs.		er 1 Year	Spring If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day	h v, Year)		ery place (State or Forei ntry) rtugal
ne Marylan 8a-f ehow	ctor	MD 10b. County Montgor		Silver		ng				1	0d. Inside City Limit
th with th	Funeral Director	9100 September La	ane		10f. Z	ip Code	20901		10g, Citizen of U	What Cour SA	itry?
permit. Pages 1 and 2 should be liled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or Items 23a or 28a-f ehow eny injury or other traumatic event. Ite Mudical Exercities result at a collisis at once.	2	11. Marital Status 1 Never Married ST Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:				spanic Origin? (S n, Mexican, Puerl Specify: Po	pecify Yes or No- o Rican, etc.) rtugal	14. Ra Bla Speci	ce - Americack, White,	
ithin 72 he e. hen "netu Madical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT	use retired)	tion uring most of wo	rking	16b. Kind of E		,
Mai y Idilia Z I Z I 3-0030 d 2 should be liled within 72 hours at th and Mental Hyglene. If is marked other then "neturel", or traumatic event, it a Mudical Exert	To Be Cor	12 17. Father's Name (First, Middle, Last) James Felix Ponte	es	T	'ailo		18. Mother's Nar	me (First, Middle,		f-Empl	loyed
nd 2 shoulth and M 27 is mar		19a. Informant's Name/Relationship (7 Joseph Pontes/son						imi Route Numbe			
oermit. Pages 1 ar Department of Hea Important: If Item: Iny Injury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	COb. Place of Disposementary, cre Gate of	matory or	other place		Date 06-2006	20c. Location	,	wn, State
permit. Departr imports eny inju		21. Signature of Funeral Service Licent	(manu	20382 2	Rap	nd Address P Fune Gist	eral & C	remation ver Spri	Servi	ce 20910	
te be ysicie	cal Ex	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Bacteria Due to (or as a co	al Sepsis onsequence of): at Urinar							Approximate Interval Between Onset and Death
death certing a strending of lor use a	nysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic p ∃ Other (s	oregnancy pecify)				ate of delive	ry Day Year
wrequires that the dibean signed by the should be detached	a by Pr	Part II. Other significant conditions co Cerebral Infarcti		_	nderlying	cause giver	n in Part I.	1			e cause of death?
sician: The law requires that the certificate has been signed by th rector, page 2 should be detached	Complete	Gangrene of Leg						24a. Was a autops perfor	SV	Were autopprior to condeath?	osy findings available of cause of 2 No
Physician: this certific ral director,	ן מ	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} 2\subseteq \text{No} \)	Hospital:	2 ER/Outpatier	nt 3 D	Other		th Check only or			
on 0 9 1		27. Manner of Death 1 whatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye			28c. Injury a Work?		28d. Describe h			7
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fun	Ceruncation	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, facto	y, office		28f. Location (Si City or Town	treet and Num n, State)	ber or Rura	Route Number,
n 24 hount n 24 hount he Funer pletely fill	edica edica	29a. Certifier (Check only one) 2 Medical Example 1	sician: To the best of money. On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred vestigation	at the time	, date and place nion, death occu	, and due to the c rred at the time, d	ause(s) and m ate and place,	anner as stand due to	ated. the cause(s)
To the To the Comp		29b. Signature and title of certifier	D N	0	29	c. License	number	2	9d. Date signe	ed (Month, L	Day, Year)
V		30. Name and address of person who co	R. Sega		Print)	MD	52261		05	-03-20	006
State	e	Alan R. Segal 150	O Forest G1		7900	r Spr	ing MD 2	0910			

DHMH 17 Rev 1/2001

PEACOCK

			For Stete Registrar	State of Maryland	/ Department of F		ental Hygie	2000	11.80
	Physic		1. Decedent's Name (First, Middle, Las ROSOCIO Jane	. 0			2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Stella Marcis	<u> </u>	4b. City, Town, o	r Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 313-76-3693 1 Usual Residence of Decedent	ex	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign ountry) uryland
	the Maryland 28a-f ehow notified at	ctor	Maryland Harford		own or Location rettsville				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th 23a or 21 ust be no	ral Directo	1301 Northal	iff Drive	10f. Zip Code	54	_	Citizen of What Co	ountry? for te S
900	hours after death with the Maryland tural, or items 23a or 28a-1 show al Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto i Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within 72 ho iene. rthan "natu Ite Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of workii	ng 16i	Own h	,
Maryland 2	should be filed and Mental Hyg marked other matic event,	To Be C	17. Father's Name (First, Middle, Last) Salvatore	Miciche	11.0	18. Mother's Name Ro 5 g l i	** CONTRACT		
	is 1 and 2 should of Health and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relationship (1) Sieven Close 20a. Method of Disposition		19b. Mailing Address (Street a 30 \ Nor + hc a of Disposition (Name of	tiff Dr. I	Darcettsv.		and 21084
Baltimore,	Page nent c ant: #		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	Duar	Lagit if I were	May 1	12006	monion	maryland
B	Departicular Depar		23a. Part 1. Enter the disease, or comp	Plications that caused the death.	22. Name and Address Pence (a) All All All All All All All All All Al	termines C Road 7	L'MUN'NW	Ward lave	J 21003
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. END STAGE DEM Due to (or as a consequen	ENTIA	<u></u>			Interval Between Onset and Death
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	ires that signed b	þ	Part II. Other significant conditions co	ontributing to death but not resultin	g in the underlying cause give	on in Part I.	23e. Did tobac		the cause of death?
	The law i ete has bi page 2 sh	Completed					24a. Was an autopsy performed 1 Yes 2 💹	prior to death?	topsy findings available completion of cause of
Vits	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 □ Yes 2▼ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA Othe	26. Place of Death			
n of	ng Phy fter this neral o		27. Manner of Death 1 XNatural 5 □ Pending	1	D. Time of linjury 28c. Injury Work		8d. Describe how i	e 6 □Other (Specially occurred	nty)
isio	Attending r death. ctor: After by the fune	catlc	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆 1	res 2□No	26 1 101		
Div	in District	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			City or Town, S	ear'	
	To the Hospital within 24 hours and to the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death occurred at the tim and/or investigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	-	29c. License		29d.	Date signed (Mont)	
	3		30. Name and address of person who c		a) (Type, Print)		MD 01000		
	Sta	te	DR. TARIQ MAHMOO	DD 2300 DULANEY 32. Registrar's Signature		TIMONIUM,	MD 21093		

DHMH 17 Rev 1/2001

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ROSARIA PROVENZA

			1 - For State Registrar	State of M	/larylan	-	artment rtificate			and Mo	ental Hy	giene	OOC	#100mag	. L. S. I	
	'Physic	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De	1 235			Time of Death	1
	/Medi		Betty J. Powers								MAY	05			19 p	М
	Exami	ier	4a. Facility Name (If not institution, g				-		Location o		·		County of D			
6	·	±38	ST AGNES 5. Social Security Number 6			last birthday)	If Under		Mo R		8. Date of Bir		ltimor			
	Funeral Director		212-58-9085	1□M 2√2F	55	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)	951	Country)	State or Fore	ign
	P.		Usual Residence of Decedent								IGIL . Z	/ , 1.	/51		71	
	arylar show	_	10a. State 10b. County			y, Town or Lo	cation								side City Limi	
	he M	Director	MD Baltimo:	re City	Balt	timore	1,,,,								Yes 2□N	10
	death with the Maryland ms 23s or 28e-f show mast be rodified at		10e. Street and Number	D.J			10f. Zip (zen of What	Country?		
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Maryland 21215-0036	after or ite	by	1 Never Married 2 Married 3 Widowed 4 ⊠Divorced	Armed Forces	s? X No	1	fYes, speci I⊡Yes 2	fy Cubar	Specify:	, Puerto R	ican, etc.)		Black, W			
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21	ithin 196.	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of worl DO NOT use	e retired)	uning most	OF WORKIN	9					
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and	d be finital H	Be	Joshua Penr								(First, Middle		Surname)			
Z	should nd Me mark metic	2	19a. Informant's Name/Relationship	0		19h Mailin	n Address	(Street a			Lle Is: Route Numb		Tour State	Zin Code	1	
	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: if item 27 is marked other then enty righty or other freumetic event, I'm M. 0DG.		Karen McKinney											, zip code	/	
Baltimore,	s fau f Hea item othe		20a. Method of Disposition			lace of Dispos	LUCAS	e of		Da	WVA	25865 20c. Lo	cation - City	or Town, S	tate	-
E	Page nent o nt: if		1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other 8per	☐Removal from State cify)	8	lar Hil	-			237 9	2006	Broo	le 1 um 1	Darle	MD	
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	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):		,				7011	10 15	10 10	YEAR	
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9	tificate ng phys as the															
O. Box	he death certificate the attending physiched for use as the I	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pred Other (spe					2	3d. Date of d Month	elivery Day	Year	
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00	> 0 10	Completed									24a. Was		24b. Were	autopsy fir	dings availabl	le
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ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical						26. Place	of Death (Check only o			3 241		
>	d is	To	examiner? 1 Yes 2 No	Hospital: 1 Inpat		ER/Outpatient	3 □ DOA	Other	4 □ Nur	sing Home	9 5 ☐ Resid	dence 6	□Other (Sp	ecity)		
Division of	ding P. After ti	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury a <i>y Year)</i>	28b. Time of Injury		c. Injury Work	?		d. Describe t	now injury	occurred			
<u>S</u> :	Attending r death. ector; After by the fune	cati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he			М		es 2 □ N							
ΣįΣ	or All after of Direction by	Certification;	4 Homicide determine	d 286. Place of Ir	niury - At hor atc. <i>(Specify)</i>	me, tarm, stre	eet, factory,	office		28	f. Location (S City or Tox	Street and vn, State)	Number or I	Rurai Rout	e Number,	
	spitai ours a verai filled	CC	29a. Certifier 1 Certifying F	hysicien: To the bes	t of my know	vledoe death	occurred at	t the time	date and	I place, an	d due to the	Cauco(c)	and manner	as stated		
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Expone)	aminer: On the basis and manner s	of examinati	ion and/or inv	estigation, i	n my opi	nion, death	occurred	at the time,	date and	place, and di	ue to the c	ause(s)	
	To the within To the Comp	ž	29b. Signature and title of certifier					License				29d. Date	signed (Moi			
•	,		abdulfat at	,,,	1.0		f	176	04		1	MAY	05	200	0	
	5		30. Name and address of person who		death (Item			AVE	BAL	-TIMO	RE	MO	21	229		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0	2006 32. R	kar's Signati	A A	horse)	9								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year VIRGINIA ALICE 8 2006 8:05 A. M PHELAN May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Baltimore Towson If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Days Hours Yrs. Director 219-22-1799 77 1928 Maryland July 30 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f sho other treumatic event, the Modical Examinar must be notified at 1X Yes 2 ☐ No Directo Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 352 Rosebank Avenue 21212 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 □ Divorced White "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be I and Menta John Nicholas Margaret Ellen Brooks Paulus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If Item 27 Is any Injury or other tree once. Ellen Phelan Wallace (daughter) 5716 Norton Road Alexandria, Virginia 22303 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Cardens 5-12-06 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Lewarse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dirator days /Medical Due to (or as a consequence of): Examiner nouman. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of) ettending physicien and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Macrocytoc Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire ၀ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. Hospital or Attendii 24 hours efter death. Funerel Director: A stely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title g 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print) MIS 7505 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

The Virina Phelan

Registrar

9 2006

Call Hand

				1 - State Registrar	State of	Marylan	d / Depa		Health and	d Mental Hy	•	06	14484
				1. Decedent's Name (First, Middle, La	ist)					2. Date of D	eath	9 9	3. Time of Death
		Physici /Medio		Mary Jane Pres	ton					May 6,	2006	Year	5:50 A M
		Examir		4a. Facility Name (If not institution, given		er)		4b. City, Town,	or Location of De			nty of Dea	
				910 Yvette Driv				Forest				Harfo	
		Funeral			Sex 7. 1 □ M 2 👽 F		last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 H	Nin. (Month, D	ay, Year)	9. Birt	thplace (State or Foreign ountry)
		Director		182-24-3925 Usual Residence of Decedent	_ X		70 113.			Nov.	21, 192	7 Per	nnsylvania
		yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
		Mar Mar	tor	Maryland Harford		For	est Hi	11					1 ☐ Yes 2 🛣 No
		or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Co	ountry?
		ath w	rai	910 Yvette Driv	T			210			USA		
		er de	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	o- 14. R	ace - Ame lack, Whit	erican Indian, se, etc.
,	36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 ☑ No	Specify:		Spec	ify: t.	Thito
8	Ö	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28s-f show he Medical Exami ar Linal be tryffled at		15. Decedent's E	ducation		16a. Deced	dent's Usual Occu	pation		16b. Kind of		Vhite Industry
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ARY Jame	Maryland 21215-0036	D = - =		19a. Informant's Name/Relationship			Muester 83			Rural Route Numb			Zip Code)
15		Health tem 27 other tr		Mary Jane Hoffmar 20a. Method of Disposition	n/ Daught	20b. P	lace of Dispo	sition (Name of		rest Hill	20c. Location		Town, State
of the	OE.	Pages nent of I ont: If its iry or o		1 ☐ Burial 2 【Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	Removal from Sta	310		natory or other pla Service		5-10-06	Towson	Ma	ryland
7	altimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Sun ture of Funeral Service Lice		\			-	Home, P.A		., 116.	Гутана
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		Physician		Immediate Cause (Final disease or condition	. Copo			RTERY		EASE			Onset and Death
		/Medical Examiner		resulting in death)		as a conseq							
	н	ZAGIIIIIOI	7	Sequentially list conditions,	b. Due to (or	as a conseq	neuce of/:						
V	$\sqrt{}$	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 (0)	20 2 0011304	451106 01).						
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	0	the a	ysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐Unknow	t at time of d	eath 5	Other (specify) _					Say Tour
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	sp.	wrequires that the de been signed by the should be detached	d by							1 🗆	Yes 2 □ No	3□Pr	obably 4 Unknown
	00	w req	iete							24a. Was	an 24b	. Were au	itopsy findings available
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	ita		BeC	25. Was case referred to medical examiner?					26. Place of D	1 ☐ Yes Death (Check only		1 1 1 1 1 1 1 1 1 1	20110
	<u></u>	hysic his ce	To	1 Yes 2 No			ER/Outpatien	t 3 DOA	ner: 4 🗆 Nursing	g Home 5XRes	dence 6 🗆 O	ther (Spec	city)
	n c	ing P	on:	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?		how injury occu		
	Sio	or Attending Physicien: ifter death. Director: After this certifica in by the funeral director, i	icati	2 Accident investigatio 3 Suicide 6 Could not be	OB COR Disease	Jaium, At ho	me form str		Yes 2 □ No	ORE Leasting	Charles and a firm		
	Division of Vital Records, P.O. Box	al or Attending Phy s after death. I Director: After this d in by the funeral d	Certification;	4 Homicide determined	building,	etc. (Specif)	y)	eet, factory, office		City or To	street and Num wn, State)	iber or Hu	ral Route Number,
6	1	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b		29a. Certifier Certifying Pl	nysician: To the be	est of my kno	wledge, death	occurred at the ti	me, date and pla	ace, and due to the	cause(s) and n	nanner as	stated.
1	2)	n 24 t n 24 t he Fu	edical	(Check only 2 Medical Exer	miner: On the basi and manner	s of examinal	tion and/or inv	estigation, in my	ppinion, death or	ccurred at the time,	date and place	, and due	to the cause(s)
100		To the To the Comp	Ž	29b. Signature and title of certifier	0	Ola	Chair	29c. Licens			29d. Date sign		- ·
	•	A		Many	Jun June	rny	SICIA		3540		MAY	8,5	8 C 60
		4		30. Name and address of person who	completed cause of	of death (Item	23a) (Type,	Print) 624	N BE	ORE M	1		
		-0	•	31. Date filed (Month, Day, Year)		istrar's Signa		(2)	ALTIM	one y	1/ 2	1205	
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Physicia		State Registrar			artment of H rtificate of I		Re	g. No.	14400
/Medica	al -	Dorothy Pie Facility Name (If not institution, give	rce		4b. City, Town, or	Location of Death	2. Date of Death Month April 28	Day Year	3. Time of Death 9:45 A
Funeral Director		Gilchrist Hospice 5. Social Security Number 511-20-9663 Usual Residence of Decedent		n yrs. last birthday) 8 Yrs.		ore City If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 7,	Year) 9. Birth Cou	place (State or Fore ntry)
8a-f ahow	ctor	10a. State 10b. County MD Baltimon		Oc. City, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2 🛣
of Health and Mental Hygiene. If item 27 is marked other than "natural," or Items 23e or 28e-f ahow or other traumatic event, the Medical Exam in prinal less codified at	Funeral Director	The state of the s	7 C 12. Was Decedent Eve Armed Forces?	or in U.S. 13.	10f. Zip Code 21286 Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto F		g. Citizen of What Cou US 14. Race - Amen Black, White	can Indian,
natural', or l	Completed by Fu	1 ☐ Never Married 2 ☐ Married 3 ঈ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grad	1 Yes 2 No If Yes, Give Year or Dates: cation e completed)		1 ☐ Yes 2 ☒ No dent's Usual Occupa	Specify: ation furing most of workir	1.	Specify: Wh:	ite
ital Hygiene. id other than " event, the Wer	Be Comple	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4	f	chool Teac		Pı	ublic Schoo	ol System
and Mental	ToB	Edward E. Watkins	rpe, Print)					City or Town, State, Zij	o Code)
nent of Healtt int: If item 27 iry or othar t	THE RESERVE OF THE PERSON NAMED IN	Robert Pierce - S 20a. Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)	town Chat-	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	e) D	ate 20	Oc. Location - City or T	
Department Important: I any injury o	Ì	21. Signature of Funeral Service Licens	rexe/	6	2. Name and Addres 224 Easte	ern Avenue	rles S. Baltimo	Zeiler & S ore, MD 212	on, Inc.
rysician Medical		23a. Part NEnter the disease, or compl shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the re cause on each line. ACUTE Due to (or as a co	CEREB	ROVASC	g, such as cardiac or ULAR D(SE	ACC()	SENT	Approximate Interval Between Onset and Death
ysicia ne bur	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	RTERY	ડાહ દ	ASE_		yos.
by the attending phy tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 270 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
egue p eq	ρ Δ	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to t	10
(0	e Completed	25. Was case referred to medical					/	prior to co death? No 1 ☐ Yes	opsy findings availa mpletion of cause of
id is	ToB	examiner?	fospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 EP/Outpatier 28b. Time o Injury	f 28c. Injury Work	at 2		ice 6 Other (Specia	Hespie
ours after death. Inled in by the tune	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)			City or Town,	·	
within 24 hours a To the Funeral to completely tilled	Medical	29a. Certifier 1 Certifying Physical Examination (Check only one) 2 Medical Examination Medical Examination (Check only one)	sicien: To the best of m ner: On the basis of exa and manner stated	amination and/or in	h occurred at the tim vestigation, in my op 29c. License	oinion, death occurre	d at the time, dat	use(s) and manner as so the and place, and due to the distribution of the distribution	o the cause(s)
within 24 hours after To the Funeral Dir. completely tilled in									Day, rear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 4487 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау **Physician** May 6, 11:30 P[™] John Joseph Quigley 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 106 Laurentum Parkway Abingdon Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1⊠M 2□ F Director 192-16-0397 83 19, 1923 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show draft wat be notified at 1 ☐ Yes 2 ☑No **Funeral Director** Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 106 Laurentum Parkway 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: other traumatic event, I've Mudical Example Be Completed by 3 ₩ Widowed 4 Divorced White 'natural' 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) 12 College (1-4or 5+) Train Director Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If item 27 Is marked of Thomas (unk) Quigley Rose (unk) Brahony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose J. Pollis / Daughter 106 Laurentum Parkway, Abingdon, Maryland 21009 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 X Removal from State ō 4 □ Donation 5 □ Other (Specify) injury Holy Rossary Cem. 5-13-06 Frackville, Pennsylvania ^{22, Name and Address of Facility}
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 any 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final Physician y eans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner burial-transit that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, IF FEMALE: for use . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an 2 No 1 Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification; To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 the 29b. Signature and Mile of Control 0 of person who completed cause of death (Item 23a) (Type, Prin Kelejewood 1945,455

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) WAY 0 9 2006

	State of Maryland / Departmen	at of Health and Mental Hygiene e of Death Reg. No. 006 14488
Physician /Medical	verna M. Rierson	2. Date of Death Month Day Year 10: 25 AM Town, or Location of Death 4c. County of Death
Examiner	Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 214-14-1146 I M 2 XF 62 Yrs. Months	Secale Tyear If Under 24 Hrs. 8. Date of Birth Days Hours Min (Month. Day Year) 9. Birthplace (State or Foreign
Director show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Dec. 30, 1923 Maryland 10d. Inside City Limits 1 Yes 2 M No
136 136 136 138 15 atter death with the Marylar atter death with the Marylar atterness 23g or 28g-1 show as cities from the multiple of the control of the c	10e. Street and Number 354 Poplar Road 2	
21215-0036 ed within 72 hours after death with the Maryland Sgiene. ver than "naturel; or Items 23a or 28a-1 show it, the Maryland Exercites translated and Maryland Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Special Status 13. Was Decedent Ever in U.S. If Yes, Special Status 14. Was Decedent Ever in U.S. If Yes, Special Status 15. Was Decedent Ever in U.S. If Yes, Special Status 16. Was Decedent Ever in U.S. If Yes, Special Status 17. Was Decedent Ever in U.S. If Yes, Special Status 18. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 10. Was Decedent Ever in U.S. If Yes, Special Status 10. Was Decedent Ever in U.S. If Yes, Special Status 11. Was Decedent Ever in U.S. If Yes, Special Status 12. Was Decedent Ever in U.S. If Yes, Special Status 13. Was Decedent Ever in U.S. If Yes, Special Status 14. Was Decedent Ever in U.S. If Yes, Special Status 15. Was Decedent Ever in U.S. If Yes, Special Status 16. Was Decedent Ever in U.S. If Yes, Special Status 17. Was Decedent Ever in U.S. If Yes, Special Status 18. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. If Yes, Special Status 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 XNo Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th 16a. Decedent's Usua (Give kind of wo life. DO NOT use the notation of the life. DO NOT use the notation of the life. DO NOT use the notation of the life.	rk done during most of working se retired)
Maryland 212 Maryland 212 d 2 should be filed with th and Mental Hygiene, t? le marked other that traumatic event, ILLA TO BE COMI	17. Father's Name (First, Middle, Last) Lester Burchette	18. Mother's Name (First, Middle, Maiden Surname) Lana May Grace
ore, Mass 1 and 2 st 1		dee Court Baltimore MD 21220 Date 20c. Location - City or Town, State PD 25/12/06 Rossville MD
Baltimore, permit. Pages 1 a Department of Hei Importent: if tem eny injury or othe	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	and Address of Facility 300 Mace Ave. Balto MD 11y Funeral Home of Essex 21221
ate be executed Thysician and hysician and the buriat-transit and t	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Onset and Death
al Records, P.O. Box 68' The law requires that the death certificat cele hes been signed by the attending phy page 2 should be detached for use as the Completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pr 4 □ Pregnant at time of death 5 □ Other (sp	
cords, P.(wequires that it s been signed by should be detac	Part II. Other significant conditions contributing to death but not resulting in the underlying cacute renal failure	ause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Reccinicien: The law recording to Be continued to Be Complete to Be Complete.	hypothyroidism Otherosclerosis 25. Was case referred to medical	24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 24\(\text{No} \) No 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 24\(\text{No} \) No
in of ing Physical distributions on: To	examiner? 1 Yes 22 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Hospital: 1 Inpatient 2 EP/Outpatient 3 DC 28a. Date of Injury (Month, Day Year) (Month, Day Year) M	26. Place of Death (Check only one) OA Other: 4 Oursing Home 5 Residence 6 Other (Specify) 18c. Injury at Work? 1 Oyes 2 One
Divertel or self or ed in Cert	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify) 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred	City or Town, State)
To the Hospi within 24 hou To the Funer ormpletely IIII	(Check only 2) Medical Examiner: On the basis of examination and/or investigation, and manner stated. 29b. Signature and title of certifier 29c.	c. License number 29d. Date signed (Month, Day, Year) 5/8/06
Ų Ståte	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Nate (Month, Day, Year) 32. Registrar's Signature	quare Drive Balto, MD 21237
Ståte Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signabuse MAY 0 9 2005	-

06-03047

Michael David Raczkowski

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Cer	tificate of	Death		Re	g. No.	5 11.1.80			
Physicia Vedical Examii	11/	1. Decedent's Name (First, Middle,Last) Michael David	Raczkowski				2. Date of Death Month	Day Year	3. Time of Death 1311 hrs			
** ~		4a. Facility Name (if not institution, give st		41	o. City, Town, o	or Location of Dea	May 5, 200	4c. County of Dea				
		2137 Graythorn Road			Essex			Baltimore Co	ounty			
Funeral Director		5 Social Security Number 6. Sex 1 X M	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Birt 06/17/	Fore	Birthplace (State or eign Country) VA			
any	-	Usual Residence of Decedent 10a State 10b. County	10c. City	Town or Locatio	n				10d. Inside City Limits			
<u>*</u>		MD Baltimore	,	Middle R					1 Yes 2 X No			
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?					
ith the Maryland 23a or 28a-f sho notified at once.		2137 Graythorn Road	d		21220			USA				
th with	Funeral	11. Marital Status 1 X Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces?			lispanic Origin? (an, Mexican, Puer	Specify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,			
5-0036 ed within 72 hours after death with the Maryland tygiene other than "natural", or items 23a or 28a-f she lite Medical Examiner must be notified at once		3 Widowed 4 Divorced If Y	Yes 2 No			o specify:	,	Specify: wh	ite			
ours afi	함	15. Decedent's Education (Specify only h	Dates:	16a. Decedent	S Usual Occup	ation (Give kind o		16b. Kind of Business				
5-0036 led within 72 hours at Hygiene other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			e. DO NOT use re	etired)					
within within giene her th	6	11 17. Father's Name (First, Middle, Last)		Plumbe	r	18 Mother's Nor	ne (First, Middle, M	Contracti	ng			
	Be C	Edward Anthony	Raczkowski			Debor		Smith				
2121! should be fill nd Mental F is marked atic event,	١٩	19a. Informant's Name/Relationship (Type				eet and Number o	r Rural Route Num	ber, City or Town, Sta				
e, MD and 2 sho Health and item 27 is traumati		Edward Raczkowski ·					, Middle	River, MD				
Baltimore, MD 2121 bernit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked nijury or other traumatic event.		1 Burial 2 X Cremation 3	Removal from State	Place of Disposit crematory or other	r place)	1		20c. Location - City of				
		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Che	esapeake L 22.Na			9/2006	Beltsvil				
Baltii permit Departm Importa	ļ	SEHOW	M0098	$\begin{array}{c c} 86 & 871 \end{array}$	A, Ste 7 Gree	bhen D. n Pastur	Lohrmann es Drive:	PA Towson,	MD 21286			
Physician		23a. Part I. Enter the disease, or complica failure, List only one cause on each l	tions that caused the death.	Do not enter the	mode of dying	g, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease a. M	ethadone intoxic						Death			
Anar		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.										
	Je		to (or as a consequence of	f):								
	Examiner	(Disease or injury that initiated	to (or as a consequence of	f):					5.1=			
ecuted and transit	ا ا	dd										
760, Teate be exergent the burial -	Physician/Medical		MENDED item#23a,		perME,G8	56,6/12/06	TT					
8760, tificate be ng physic as the bur	Ž	3b. Was decedent pregnant in the	23c. If yes, outcome of pregr		Ideath 3	Ectopic preg	nancy	23d Date of deliver	ery Day Year			
Box 68 e death certil the attending ed for use as	sicia	past 12 months? 1 Yes 2 No 9 Unknown		ath =	er (Specify)		Í	V	,			
P.O. Box 687 s that the death certifing gned by the attending cetached for use as t	ᇍ	Part II. Other significant conditions co	Unknown	esulting in the un	derlying cause	niven in Part I	23e Did tot	pacco use contribute t	o the cause of death?			
cords, P.O. law requires that the has been signed by					acity it ig bases	9.70.7.1.7			obably 4 Unknown			
rds, requir been s	letec						24a. Was a		autopsy findings available			
2 et = ± 8 et = 5 et = 1 et =								ned? death?				
F Vit	٥.	1 ✓ Yes 2 No	T Inpatient Z	ER/Outpatient				Residence 6 🗸 Oth	er: Scene			
nding l h. Afte e funer	ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj		ury at Work? Yes 2 x No	1 .	ow injury occurred				
iSiO	icati	2 Accident Investigation	Fnd 5/5/2006 28e. Place of Injury - At ho	Fnd 1:00 ome, farm, street	1		unk 28f Location (S	treet and Number or F	Rural Route Number, City			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	3 Suicide 6 X Could not be determined	(Specify) House			0.	Middle R	_{ate)} 2137 Gray Lver, MD	Rural Route Number, City Thom Road			
e Hosp 124 ho e Func etely f			To the best of my knowledge									
To th within To th	Medical	one) 2 Medical Examiner: Or an 29b. Signature and title of certifier	d manner stated	nd/or investigatio			at the time, date a					
0:			211			.M.E.		29d. Date signed (M May 6, 2006	опт, рау, <u>теаг</u>)			
D. J.	-	30. Name and address of person who com	pleted cause of death (Item	23a)								
863			tant Medical Examin	er 111 Pe		Baltimore, MD	21201					
		31. Date filed (Month, Day, Year) MAY 0 9 2006	32. Registrar's Signatu	re	1			····				
Regist	للت	WALLE	Marie As	0 /								

			1 - For State Registrar	State of Ma	ryland		rtment tificate			.nd M		giene Reg: No.	6	4490
	Physici	an	Decedent's Name (First, Middle, Last)	_							2. Date of De Month	ath Day	Year 2006	3. Time of Death 5:45 P M
	/Medic Examin		4a. Facility Name (If not institution, give	E. street and number) HOSPICA	RUSS HL	ELL_			Location of		MAY	4c. County	of Death	3. (3 (
	Funeral Director		5. Social Security Number 6. Sec 562-54-5238	7. Age	(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird Sept.	14,1919	9. Birthp Coun Mar	lace (State or Foreign stry) yland
	Maryland	tor	10a. State 10b. County Maryland Anne Art	1		Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 🗹 No
	th with the 23a or 284	al Directo	10e. Street and Number 2252 Lake Drive				10f. Zip	Code 2112	22	14		10g. Citizen of 1		ntry?
980	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "naturel", or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No Rican, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White, y: Whi	etc.
21215-0	filed within 72 h Hygiene. ther than "natu int, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or 5+			ent's Usua kind of wor OO NOT us 'Ograll	k done d e retired)	tion uring most	of workin	g	16b. Kind of B		
yland	2 should be filed and Mental Hygin is marked other raumatic event,	To Be (17. Father's Name (First, Middle, Last) Walter A	. Hobbs						's Name ciett		Maiden Suman Coale	,	
Baltimore, Maryland 21215-0036	of Health of Health f Item 27 ir other t		19a. Informant's Name/Relationship (Ty. Doris Lynn Eaton 20a. Method of Disposition 1 1 Bunal 2 □ Cremation 3 □ R	(Daughter)	20b. Plac	204 S se of Dispos netery, crem	hana sition (Nam patory or ot	Road	l, Gle	en Bu	ırnie,	Marylan 20c. Location	d 210	060 wn, State
Baltim	permit. Pages Department of Important: If It eny injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		Lake		Name and	d Address	s of Facility			Sykesvi Lome P.A Mar		Maryland
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.	ι. (Do not ente	or the mode	of dying		ardiac or	respiratory ar		yrana	Approximate Interval Between Onset and Death
8760,	3	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		nce of):	unc				4 10			
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 TNo 9 Unknown	3c. If yes, outcome of 1 ∐Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal de	eath 3 🗌	Ectopic pre Other (spe						ate of delive	ny Day Year
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al Reco	The law ate hes b page 2 s	Completed									24a. Was autop perfo 1 Tes	rmed?/	prior to cor death?	psy findings available inpletion of cause of 2 No
Division of Vital Records,	ding Physicien: Th. 1. After this certificate funeral director, pag	on; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	o spital: 1 Unpatient 28a. Dale of Injury (Month, Day)	28	VOutpatient 3b. Time of Injury		A Other	r: 4 🗆 Nur	sing Hom		ne) dence 6 Oth now injury occur		')
Divisio	or Attendent death Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, elc.	y - At home		М	1 🗆 Y	es 2□N		8f. Location (S City or Tox	Street and Numb vn, State)	per or Rura	l Route Number,
=6	ne Hoepital n 24 hours en ne Funeral bietely filled	edical Co	29a Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	tician: To the best of ter: On the basis of e and manner state	xamination	adga, daath n and/or inv	occurse a estigation,	it the time in my op	e, date and inion, death	place, and occurre	nd due to the o	caues(s) and inc date and place,	and due to	atou. the cause(s)
)	To the within 2 To the complete	We		WELAIA	VAZ	Mi, M	D	P- [number F610			29d. Date signe	d (Month, I	Day, Year)
	6		30. Name and address of person who co White M. White 24 31. Date filed (Month, Day, Year)	mpleted cause of dea	01	KYNE	erint)	4) TA	. 9	60. S	10343	V AVE.	BACT	imare moan
2	Sta Registr		MAY 0 9 20	06 32. Hegistran	a dignatult	1	soft 5							

_			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygi	_	6 4491
	Physic		1. Decedent's Name (First, Middle, Last) Albert George Rickter	2. Date of Death Month	Day	Year S 35 P M
	/Medi Examii		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County	<u> </u>
			Franklin Square Hospital BosEdalE		Bal	timore
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 213 - 26 - 4760 Yrs. Months Days Hours Min.		Year) 1929	9. Birthplace (State or Foreign Country) Maryland
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			
	ath with the Marylar 23s or 28e-f show	5	Maryland Baltimore Perry Hall			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e-	rect	10e. Street and Number 10f. Zip Code	10	g. Citizen of W	^
-5	th with	aiD	9615 B Haven Farm Road 21128		U.S.A	•
•	after dea or Iteme	uner	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc.
BER4	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28e-f show isa Mudical Examiner must be notified at	Completed by Funeral Director	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 1 □ Yes Give N ULCAN Year or Dates: Conflict 1 □ Yes 2 □ No Specify:		Specify:	
18ER	72 ho	eted	15 Decedent's Education 163 Decedent's Haral Convention	rkina		siness/industry
121	within	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		Self-Em	iployed Lestaurant
A 2	71 75 4 77	ပိ		me (First, Middle, M		
'an	should be nd Mental marked c matic eve	To Be	Charles J. Rickter Margare		nuska	•
Tany Pary	2 shol and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			
e ()	ges 1 and 2 should be filed to fleath and Mental Hyg If Item 27 is marked othe or other traumatic event,		Mrs. Betty Rickter (wife) 9615 B Haven Farm Rd. 20a. Method of Disposition (Name of			
nor (eges ent of ht: If It		20a. Method of Disposition 1 \(\overline{\text{Meurial}} \) 2 \(\overline{\text{Cremation}} \) 3 \(\overline{\text{Removal from State}} \) 4 \(\overline{\text{Donation}} \) 5 \(\overline{\text{Other (Specify)}} \) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Dulaney Valley Mem' \(\overline{\text{5/10}} \)			City or Town, State
Baltin	permit. Pege Department of Important: If eny Injury of once.		21. Signature of Tursiral Service bicensee 22. Name and Address of Facility Sc.			
	Depa Impo eny le		Ille 9705 Belair Rd., 1			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death
	Examiner		Due to (or as a consequence of):			
	ם פ	ner	Sequentially list conditions, if any, leading to immediate causa. Enter Unidenyling Cause (Disease or injury that indiated events c.			
V	and I-trans	Examiner	Cause (Disease or rijury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760,	ate be executed hysician and he burial-transit	calE	d			
	tific g p as t	-	IF FEMALE:			
Division of Vital Records, P.O. Box 68	ath ce attendi for use	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date	of delivery th Day Year
Ö	t the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			52,
G,	ires that signed b d be deta	oy Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contri	bute to the cause of death?
ord	v require been sig should b			1 ☑ Ýes	2 □ No :	3 Probably 4 Unknown
3ec	elawi hasbu je 2 sh	Completed		24a. Was an autopsy	24b. W	ere autopsy findings available for to completion of cause of
<u> </u>	ician: Th certificate rector, pag		25. Was case referred to medical		No 11	eath? □ Yes 2☑ No
Ž.	ysicia is cert directo	To Be	examiner? Hospital:	ath <i>Check only one</i> Iome 5 🗆 Residen		r (Snecity)
0	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how		
isio	Attendi death. ctor: A y the fu	icati	2 Accident investigation M 1 Yes 2 No	004		
Div	after Direct	Certification:	4 ☐ Homicide determined determin	City or Town,	State)	r or Rural Route Number,
	To the Hospitel or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	, and due to the cau	use(s) and man	ner as stated.
	the H hin 24 the F mplete	Medicai	and mariner stated.			
	To To Con		29b. Signature and title of certifier 29c. License number 29c. Lic	_ /	5/7/0	(Month, Day, Year)
	(11		30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)		1.70	f -
	57'		Dr. Layra Steel = 9000 Year Klin Square dr.	Baltin	NORE, 1	1D 2137
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			_
DH	MH 17 Rev 1/2		MAY 0 9 2006 Jane & Janes			
			ORIGINAL			

			1 - For State Registrar	State of Maryl	and / Dep		t of H	ealth ar	nd Me	F	Reg. No.)06		92		
100	Physici		1. Decedent's Name (First, Middle, Last, Geraldine)	Rio	chards	son		2	2. Date of Dea Month 4	26	2006	3. Time of 7:a	Death M		
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City,		Location of I	Death		4c. County of Death Baltimore					
2	Funeral Director		5. Social Security Number 6. Security Number 216-20-2254	7. Age (In)	vrs. last birthday) Yrs.	If Under Months		If Under 24 Hours	Hrs. 8	3. Date of Birt (Month, Day 6-21	h /, Year) -27	9. Bii	rthplace (State of country) Md.	r Foreign		
	ne Maryland 8a-f ehow	Director	10a. State 10b. County Md. NA	10c.	City, Town or Lo	ore							10d. Inside Ci 1X Yes			
	with the	Dire	10e. Street and Number 1201 Harwood A	ve.		10f. Zip	Code 21239)			10g. Citizen of What Country? USA					
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28s-f ehow Is Modical Exercitive transite rodified at	d by Funeral		12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, spec	Was Decedent of Hispanic Origin? (Specify Yes or I f Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:					No- 14. Race - American Indian, Black, White, etc. Specify: Black					
	within 72 he jiene. r than "natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us -Emp]	rk done d se retired)	u <i>ring m</i> ost o	of working	7		of Business autici				
מס	e filec I Hyg othe	Be Co	12th grade 17. Father's Name (First, Middle, Last)		BCII	- 111101	Joyce		s Name (First, Middle,						
<u>S</u>		10	Nathaniel Ray Alverta									Bethe				
Baltimore, Maryland	ulth ar 27 is r trau		19a. Informant's Name/Relationship (Ty Harvey Nevels	ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Son 1201 Harwood Avenue, Baltimore									Zip Code) 21239			
	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Mailloval Irotti State	Mt. Carmel Cem. 4-28-06						20c. Location - City or Town, State Dundalk, Md.					
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	Wano				s of Facility East	:	Balt 1101 E.		e, Md. th Ave				
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dependence cause of each line.	leath. Do not ent	ter the mod	e of dying	, such as ca	ardiac or i	respiratory ar	rest,		Approximate Interval Bett Onset and E	ween		
68760,	death certificate be executed e attending physician and d for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to initial distance. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last													
P.O. Box 68	that the death certifica led by the attending ph detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23	3d. Date of delivery Month Day Year				
	90 P	þ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying c	ause give	n in Part I.					o the cause of d			
Records,	The law ate has b page 2 s	Completed										prior to death?	utopsy findings a completion of ca s 2 \(\text{No} \)	available ause of		
of Vital	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Othe	. 1		Check only						
ion of	ding h. After fune	tion: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o Injury		8c. Injury Work	at	28	5 🗌 Resid d. Describe h			ecify)	Para de Proposition		
Division	F 6 F L	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location							on (Street and Number or Rural Route Number, r Town, State)					
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	h occurred vestigation,	at the time in my op	e, date and p inion, death	place, an occurred	d due to the c at the time, c	ause(s) a late and p	nd manner a lace, and due	s stated. e to the cause(s))		
•	To the within To the comp	Me	29b. Signature and title of certifier	A			License	~ 9			29d. Date signed (Month, Day, Year) 5-5-06 78 Town MD 212dy.					
	3		30. Name and addless of person who ca	ung, ly		Sring)	Priv	re Si	unte	208	Tor	uso o	ND 5150	LJ.		
	Sta Registr	_	31. Date filed (Month, Day, Year) WAY 0 9 20	32. Figistrar's Si	gnature	costs.	9									

06-02877 William Rudisill

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

rillarii redosiii		For State Certificate of Death Registrar		g. No. 200	6 11,1,99					
Physicia	n/	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 2216 hrs					
/ledical Examir		William Rudisill	April 28, 20	006						
A. Carrier		4a. Facility Name (if not institution, give street and number) 4920 Belair Road 4b. City, Town, or Location of Death Baltimore		4c. County of Death						
Funeral Director		197-34-0088 1XM 2 F 63 Yrs. Months Days Hours Min.	1	(MM/DD/YYYY) 9. Bir Foreig 6, 1942 Co						
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
Aaryland 28a-f show 1 at once.	5	MD Baltimore			1 X Yes 2 No					
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?					
th the Maryland 23a or 28a-f sho notified at once.		4920 Belair Road 21206		USA						
215-0036 be filed within 72 hours after death with the Maryland mial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	uneral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Spin Yes, specify Cuban, Mexican, Puerto I		14. Race - Amer White, etc.	ican Indian, Black,					
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: wh						
hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retin		16b. Kind of Business	Industry					
136 hin 72 e. than '	ompleted	12 2 Disabled		None						
5-0036 led wittin 72 hours afte Hygiene. I other than "natural", the Medical Examiner	8	17. Father's Name (First, Middle, Last) 18. Mother's Name unk	(First, Middle, M							
0 a >	Be	Nadine W			5.0.1					
timore, MD 2: 1. Pages I and 2 should ment of Health and M reant: If item 27 is m:	٩	19a. Informant's Name/Relationship (Type, Print) Albert R. Allen/friend 19b. Mailing Address (Street and Number or R 4920 Belair Road Balti			e, Zip Code)					
and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date M	20c. Location - City o	Town, State					
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)								
Baltimo permit. Page Department of Important: injury or ott	ł	4 Donation 5 X Other Specify: in state 21. Sign in e of Fun-ral Service Licensee 22. Name and Address of Facility		100						
E F G E		Director State Anatomy Board Baltimore MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	655 W.	Baltimore	Street					
Physician /Medical	1	failure. List only one cause on each line.	respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death					
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disseae Due to (or as a consequence of):			Death!					
7		Sequentially list conditions, b								
	in	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
red nsit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED								
x 68 1 certif ending use as	Physician/Me									
O.O. BOy that the death ned by the att	hys	1 Yes 2 No 9 Unknown 9 Unknown	22a Didaa	hanna una contributo te	the equipped death?					
, P.O. res that th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Amyotrophic lateral sclerosis		bacco use contribute to	bably 4 V Unknown					
ords, F aw requires has been sign 2 should be	ed	7 Hilyottopillo lateral octoroco	24a. Was a		utopsy findings available					
COF	Completed by		autops	med? death?	completion of cause of					
ral Re		25. Was case referred to medical 26.Place of Death (Check of D		2 N 1 1 Y	es 2 No					
Vita hysicia this cel	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursin	g Home 5	Residence 6 🗸 Othe	er: Scene					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the finneral director, page 2 should be	T:U	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	now injury occurred						
SiOI Attence r death ector: by the	catio	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc.	28f Location (S	Street and Number or R	ural Route Number, City					
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Si		,					
Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause t the time, date a	e(s) and manner as sta and place, and due to t	rted. he cause(s)					
Ž ½ ₹ 8	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)					
*		alillett O.C.M.E.		April 29, 2006						
		 Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21: 	201							
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Regis		MAY 0 9 2006 /2000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Amend Certificate of Death Reg. No. #10b, d&20b Per FH G855 2. Date of Death Month Day Year **Physician** 1:40 A M Harru 2006 /Medical 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospi Ba Baltimore Itimore Cit 8 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 219.14.0330 1**X**M 2□ F Director 04 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at MD Baltimore + No Director Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Road 21234 USA Halstead Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Black Specify Completed by 3 XWidowed 4 ☐ Divorced Year or Dates "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hanger 12 should be filed within 7 h and Mental Hygiene.
7 le marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Cleaners Company Assembly Morker NIA 7th arade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Rainer Rainey Ivene 19a. Informan's Name/Relatio (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Denise Raineu Baltimore MD 21234 Daughti 1134 Halstead Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of I Important: If it eny Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 270n 5/12/06 4 □ Donation 5 □ Other (Specify) 22, Name and Address of Facility VOULD UN C. Green C FUNCIAL SENVICED 4400 York Road Balfimore MD 21212 21. Signature of Funeral Service Licensee leur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia **Physician** das disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 3 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Sinai HOS DITA Kim 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 9 2006

DHMH 17 Rev 1/2001

			For State	State of Maryla		artment of H <i>tificate of L</i>			OBBO		
			Registrar 1. Decedent's Name (First, Middle, Last	t)			Jean	2. Date of Death	g. No.	3. Time of Death	
100	Physici /Medic		CHARLES	ROCKEN	JBAU	IGH	I de la contraction de la cont	MATH	05 2006	4:55P M	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	lumbia	4c. County of Dea	™ Howard	
	Funeral		5. Social Security Number 6. Se	County General Ho	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign	
	Director		213-09-6138	M 2□F	91 Yrs.	Months Days	Hours Min.	January 8		Maryland	
	p ,		Usual Residence of Decedent	100	City Taylor and			- January o	, 1813	10d. Inside City Limits	
	shov	2	10a. State 10b. County		City, Town or Lo					1 Yes 2 No	
	the M	Director	Maryland Bal 10e. Street and Number	timore		10f. Zip Code	llicott City	10	og. Citizen of What Co	-	
	with 3a or		2417 Westchester Ave			Tor. Zip Godo	21043		•	.S.A.	
	death rms 2:	Funerai	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination that be notified at once.	þ	1 Never Married 250 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	nican, etc.)	Specify:	White	
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2	Hygie ther t nt, th	ပိ	17. Father's Name (First, Middle, Last)			Polic	ce Colonel	e (First, Middle, M	faiden Surname)		
au	d be annual	To Be		Rockenbaugh					Virginia Bryan		
37	should to	F	19a. tnformant's Name/Relationship (T	City or Town, State,							
	and 2 eith a 27 is		Mrs. Margaret Rockenba	augh Wife	2	2417 Westche	ester Ave Elli	cott City, Ma	ryland 21043		
ore	of Herr f Item r oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I		o. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date 2	20c. Location - City or	Town, State	
Ĕ	Pag ment ant: f		4 □ Donation 5 □ Other (Specify,			hepherd Cem	retery	/09/2006	Ellicott Ci	ity, Maryland	
Baltimore,	Depart Import any in		21. Signature of Funeral Service Lices:	Brok	10,293 22		uneral Hom		City, MD-2104	3	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of				Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition	SEPTIC	SHO	ell				Onset and Death	
	/Medical Examiner		resulting in death)		2.3						
	Examiner	_	Sequentially list conditions,	b. RENAL		UPE				a vans	
J	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	1	1EARS					
	akecu al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					Chi	
68760,	ificate be executed g physicien and as the burial-transit	edical	(d							
_		Medi	IC COMME								
Box	aath certii attending for use a	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of de Month		
P.O. E	ires that the des signed by the at t be detached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5□	Other (specify)				51,	
	that the by detact	y Ph	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?	
rds	quires n sign uld be	ad by						1 □ Ye	s 2□No 3□P	robably 4 Dunknown	
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ō	Attending Physicien: r death. ector: After this certificaby the funeral director, I	2	27. Manner of Death	28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of	IT 3LI DOA	4 Nursing H	ome 5 ☐ Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	ecity)	
<u>0</u>	nding I ith. r: After e funer	ation	Matural 5 ☐ Pending 2 ☐ Accident investigation		') Injury		k? Yes 2 □No				
Division of Vital Records,		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,	
	To the Hospital or within 24 hours effer To the Funerel Dir completely filled in	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occur	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)	
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	ma , algo	\	29c. License	e number	25	d. Date signed (Mon	th, Day, Year)	
)	_		man	Mary 143		D53	787	A	174; 6	2006	
	8		30. Name and address of person who of	ompleted cause of death (Item 23a) (Type,	Print) KEN	NETH	CEH,	MD 2126)(.	
it.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature						
	Registr	al	WAY 0 9 Z	UUD 1 Paralla 12 1	200						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, perMistate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 00 G **Physician** 11:28 PM oanna SUI 1111 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 altimore lizabeth vsing Center Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age In yrs. last birthday) **Funeral** 79 1 ☐ M 2 🗙 🗶 Days 218.22.4653 Yrs. Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County frams 23a or 28a-f show ner / wat be nutified at XXYes 2 □ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21227 3320 Benson Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2XXNo Specify: Specify: White other traumatic event, the Mudical Exac 3 Widowed 4 □ Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked or John Slusher Myrtle Borcherdini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Magothy Bridge Rd., Pasadena, MD. if itam 27 Sandra Riley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fermation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department of Important: If any njury or once. May1,2006 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, MD. 22. Name and Address of Facility
Fink Funeral Home , P.A. of Funeral Service L Enter the displace, of amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 21061 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ancer **Physician** una WITH months resulting in death) /Medical Due to (or as a consequence of): Examiner ranavy distait V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sicien and burial-transit or Attending Physicien: The law requires that the death certificate be executed abetes ars that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown 24b. Were autopsy findings available prior to completion of cause of death? -emi 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) -engon verule 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

9 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar					Certific	cate of	Death	7		, ,	R	eg. No.	See.	UU	0	44
Physicia	an/	Decedent's Nam	e (First, Middl	e,Last)			_					2	. Date of Dea Month		Year		me of Deat	th
ledical Exami	ner	Michael											May 4, 20	06		1	116 hrs	
		4a. Facility Name (Elk River ne		-				4	4b. City, To Elkton		ocation of	Death		4c. C	County of De	eath		
Funeral	-	5. Social Security N		6. Sex			yrs. last bi	irthday)	If Unde		If Under	24Hrs.	8. Date of Bi	of Birth(MM/DD/YYYY) 9 Birthplace (State or				
Director		164-52-985	54	1 X M		48		Yrs.	Months		Hours	Min.	11/15/1			eign PA Country)		
any	ŀ	Usual Residence o 10a. State	f Decedent 10b. County		-	10c.	City, Tow	n or Locati	on							10d	Inside City	Limits
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Physician		23a. Part I. Enter the failure, Life or	ne disease, or nly one cause	complication on each lin	ns that cau e.	used the d	death. Do r	not enter th	ne mode o	f dying, su	uch as car	rdiac or re	espiratory ari	est, shock	k, or heart		oroximate I tween Ons	set and
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i, P.O. Bc ires that the dea signed by the a		Part II. Other sign	ificant condit	ions cont	ributing to	death but	not resulti	ing in the u	inderlying	cause giv	en in Part	t I.	23e. Did t	obacco us	e contribute	to the ca	use of dea	ath?
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ital Rec ician: The certificate rector, page		25. Was case refer	rred to medica	1					2	6.Place o	f Death (0	Check on		2	, •	-		110
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Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been seled in by the funeral director, page 2 should	-1	27. Manner of Dea		2	8a. Date of	f Injury Day, Year)		. Time of I	njury 2	8c. Injury	at Work?		8d. Describe ubject dro			kina		
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ivision or Atten after death Director:	ij	3 Suicide	6 Cou	d not be	28e. Place		- At home,	farm, stree	et, factory,	office bui	Iding, etc.	2	8f. Location (or Town,		Number or	Rural Ro	ute Numb	er, City
Di spital sours a neral I	Certification:	4 Homicide	dete	rmined	(Specify)	River						E	lk River n	ear 230	8 Old Fie	ld Poin	t Road,	Elkton
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier (Check only one)	Certifying P Medical Exa														se(s)	
To th within To th comp	Medical	20h Sidhatura and	title of certific	and	manner sta		and and/or	vcaligat		License		uneu at t	ne une, uate					
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2	tate					istrar's S		. 2			-,							
Regist			MAY 0	9 2006	5 1	28.00	M	Co	ache s									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 5 2006 4:30a M M. Smith Ada /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore Manor Care - Rossville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Year) | Feb. 6, 1927 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 79 213-20-7750 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other than "naturel", or items 23s or 28s-4 show other traumatic event, it is Medical Examinar must be notified at Essex 1 Tyes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 349 Nicholson Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOTUse retired)
Homemaker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walters Wilbert H. Linton Emma H. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2...
Department of Health at Important: If item 27 ie any injury or other trau 349 Nicholson Road Balto. MD 21221 /daughter Diana Jones 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 5/8/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Monily /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dualto for its it consecuence off-Examiner Tany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sicien and burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical phys. the b use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown ō Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? (es 22 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funerel D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9512 Harford Road Parkville MD Dr. Rahnama 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DOB,

SWith,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 2 per doc 2855 5-12-06 vt.

State of Maryland / Department of Health and Mental Hygiene.

		For State Registrar				Cert	ificate	of D	eath		Reg.	No. U	JO	144
D1 1 1		1. Decedent's Name (First, Middle,	, Last)					-,		2. Date Mor	of Death	7 Day	Year	3. Time of De
Physicia /Medica		Anthony		Α		Sill	Jr.			M			006	c2:30
Examine	-	4a. Facility Name (If not institution,	, give stre	et and number)			4b. City, T	-	ocation of Deal	th		4c. County		4
		Baltimore Washin	naton	Medical	Cente	r	Gle		iunie			Anne	Arc	undel
neral			6. Sex	7. Age	(In yrs. la:		If Under 1 Months	Year Days	If Under 24 Hrs Hours Min.	8. Date	of Birth oth, Day, Ye	ar)	9. Birthr	olace (State or Fo
ctor	-	213-26-5490	I MRI IVI	201	76	Yrs.				Aug	3. 24,	1929	Mar	ryland
4577	-	Usual Residence of Decedent 10a. State 10b. County			10c, City.	Town or Loca	ation							10d. Inside City L
a d	5			1 4	_									1 □ Yes 2
all l	ect	Maryland Anne	Arun	idel	Gle	en Buri		2-4-			10-	Citizen of V	Mhat Cau	
2 7	Funeral Director	10e. Street and Number	1 B				10f. Zip 0		1		109.			
H .	-ra	406 Hidden Broo		CIVE APT. Was Decedent E		12 W		2106		Sanaity Va	a or No		U.S.A	an Indian.
Jer.	Ĕ	11. Marital Status 1 □ Never Married 2 ☑ Marrie		Armed Forces? 1 X Yes 2 □ N		is. if	Yes, specif	fy Cuban	panic Origin? (S , Mexican, Puer	to Rican, e	etc.)		ck, White,	
T SE	Ş	3 ☐ Widowed 4 ☐ Divorced	eu	If Yes, Give Year or Dates:		1 (☐Yes 2	⊠ No	Specify:			Specify	/: [nite
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u'		17. Father's Name (First, Middle, L	Last)	= 2			4100111		18. Mother's Na	me (First,				
6 1	To Be	Anthony	Α.		Si	ll, Sr			Marie				W-	ilson
mat	-	19a. Informant's Name/Relationsh			01.			(Street ar	nd Number or R	ural Route	Number, Ci	ty or Town,		
Tra	- 1	Jean E. Sill ((Wife	ر د		406.1	ahhiH	n Br	ook Dr	Δnt	E Gle	n Bur	nie 1	4D 21061
othe	1	20a. Method of Disposition	LVILL	٠,	20b. Pla	ce of Disposi	tion (Name	e of	OOK DI.	Date	200	. Location -	City or To	own, State
y or		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		noval from State		yview (i .	0/06	P	01+im	oro	Mary1an
important. Interest a manner until train lauran, or removed to consider any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Fuperal Service L		123	ва	22	Name and	Address	of Facility					
eny ir		MI	//	// -		Mo	cCull	y-Pc	lyniak ain Roa	Funer	cal Ho	me, P	.A.	1 01100
	-	23a. Part Enter the disease, or o	complica	tions that caused	the death.							, Mar	YIAUC	Approximate
		shock, or heart failure. List of Immediate Cause (Final	only one											Interval Between Onset and Dea
ian cal	Ì	disease or condition resulting in death)	_ a	Emphy Due to (or as a	,									
ner				Due to (01 25 2	Conseque	nice oi).								
	ē	Sequentially list conditions, I y saying to min adult cause. Enter Underlying Cause (Disease or injury that initiated events	b. –	Due to or as a	a conseque	nce of								
. sit	Examiner	Cause (Disease or injury	S											
- i	Exa	resulting in death) Last	Ç.	Due to (or as a	conseque	nce of):								
s the burial-transit	cal		d.											
as th	edical											1		
esn	2			If you autooma	of pregnance							23d. Da	te of deliv	ery
<u>ئ</u>		IF FEMALE: 23b. Was decedent pregnant	23c.			looth 2 E	atonia ara							Day Yea
0	100	23b. Was decedent pregnant in the past 12 months?	23c.	1 ☐Live birth : 4 ☐ Pregnant at			Ectopic pre Other (spe					Мо	onth	Day 196
tached	hysicle	23b. Was decedent pregnant	23c.	1 Live birth					ŭ	-		Мо	onth	Day 16a
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ORIGINAL

			For State Registrar	Otate of	iviai y lai i		rtificate			iu ivie		Reg. No.		1 1000		
	Physic /Medi		Decedent's Name (First, Middle, Li	as <i>t)</i> Pear	1 L.	Smith				2	2. Date of Dea Month 4	Day	Year 2006	3. Time of Death 9:00 p. M		
-	Examir		4a. Facility Name (If not institution, gi		er)				Location of [Death		4c. Cour	nty of Death	-		
		100	9773 Groffs Mi						Mills	Hen			Balt.			
¥	Funeral Director		219-01-2856	Sex 1 □ M 2 XF 7.	Age (In yrs. Ia	Yrs.	If Under Months		If Under 24 Hours	Min.	Date of Birtl (Month, Day 9-15	n /, Year) -1917	9. Birth	place (State or Foreign ntry) N. C.		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							I Od. Inside City Limits		
	e Maryli Ba-f sho	Director	Md Ba	alto		ngs Mi								1 ☐ Yes 2 🕅 No		
	with the sa or 2	Dire	10e. Street and Number 9773 Groffs Mills	s Blvd			10f. Zip	Code 1117	,			10g. Citizen o US		ntry?		
	heath	era	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. V				2 (Speci	fv Yes or No-		ace - Americ	can Indian		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menial Pygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinal mental ternolitied alonge.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Force	1 ☐ Yes 2 1 No If Yes, Give Year or Dates: ucation te completed) 16a. Deced (Give Iifa				Specify:	Puerto Ri	fy Yes or No- can, etc.)	В	Black, White, etc. Specify: Black (ind of Business/Industry			
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land	ild be fill lental H ked ott	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mid													
ary	shou and W s mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a			Route Number, City or Town, State, Zip Code)					
e, Z	1 and 2 Health am 27 i		Gregory M. Smit	n - Son	20b PI	4011 ace of Dispo	McDo	nogh	Road	Dai	kandall	Lstown 20c. Location				
Baltimore, Maryland	Pages nent of ant: If it ary or o		1XXBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		ate ce	ng Mem	natory or ot	her place		-5-20		Randali	,			
Balt	permit. Departimporta eny inju		21. Signature of Funeral Service Lice	ensee /	1	22			s of Facility abash		rch F/l ue Ba	H Wes	_	215		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau	sed the death	. Do not ent								Approximate Interval Between		
5	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.		MER	INE	CAL	CER					Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):													
Į	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	ence or):	M	413								
	and and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or	Due to (or as a consequence 1):											
68760,	ntiticate be executed ing physician and a as the burial-transit	Wedical E		d	as a consequ	ence on.										
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Ś	9 5 4	by	Part II. Other significant conditions	contributing to deat	h but not resu	Iting in the ur	nderlying ca	use give	n in Part I.	_	23e. Did to	~		ne cause of death? eably 4 □Unknown		
Record	e law requir has been s ge 2 should	Completed									24a. Was a	sy	prior to co	psy findings available		
<u> </u>	Th ate pag										perfor	2/Z No	death? 1 ☐ Yes	2×No		
Ħ	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Othe	E		Check only or					
o	Phys this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inp		R/Outpatien 28b. Time of		~	4 🗆 Nursi			ence 6 🗆 O		γ)		
ion	Attending Physician: r death. sctor: After this certifica by the funeral director,	atlon	1 Natural 5 ☐ Pending investigated	(Month,	Day Year)	Injury	M	Bc. Injury Work	ai ? ′es 2 □ No		d. Describe h	ow injury occ	urrea			
Division of Vital	afor Atterage after de I Directo	ertification:	3 Suicide 6 Could not 6 4 Homicide determined	289. Place of	Injury - At hor etc. (Specify,	ne, farm, stre	eet, lactory,	office		28	Location (Si City or Town		mber or Rura	l Route Number,		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying P	hysician: To the be miner: On the basis and manner	s of examinati	vledge, death on and/or inv	occurred a restigation,	it the time	e, date and p inion, death	olace, and	d due to the c at the time, d	ause(s) and r late and place	nanner as s e, and due to	tated. o the cause(s)		
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	100	+ m		29c.		number	21	2	9d. Date sign	ned (Month,	Day, Year)		

State Registrar